



**Royal Berkshire**  
NHS Foundation Trust

# Public Board - 27 May 2026

MEETING

27 May 2026 09:00 BST

PUBLISHED

22 May 2026

# Agenda

Location	Date	Time	
Seminar Room, Trust Education Centre, Royal Berkshire Hospital	27 May 2026	09:00 BST	
Item	Owner	Time	Page
1 Apologies for Absence and Declarations of Interest	Oke Eleazu		-
1.1 Janet Lippett & Katie Prichard-Thomas, Andrew Statham			-
2 Staff Story (Verbal)	Katie Prichard-Thomas	09:00	-
3 Patient Story (Verbal)	Katie Prichard-Thomas	09:30	-
4 Minutes for Approval: 25 March 2026 & Matters Arising Schedule	Caroline Lynch	10:00	3
5 Minutes of Board Committee Meetings and Committee Updates:		10:05	-
5.1 Audit & Risk Committee: 11 March 2026 & 13 May 2026 (Verbal)	Mike McEnaney		12
5.2 Finance & Investment Committee: 18 March 2026 & 15 April 2026 & 20 May 2026 (Verbal)	Mike O'Donovan		19
5.3 Quality Committee: 22 April 2026	Helen Mackenzie		29
5.3.1 Committee Review of Effectiveness and Terms of Reference			37
5.4 People Committee: 7 May 2026 (Verbal)	Catherine McLaughlin		44
5.5 Charity Committee: 6 May 2026	Catherine McLaughlin		46
5.5.1 Committee Terms of Reference			52
6 Chief Executive's Report	James Blythe	10:30	54
7 Integrated Performance Report	Katie Prichard-Thomas	10:50	60
8 Standing Financial Instructions	Frances Khatcherian	11:15	88
9 National Oversight Framework	Andrew Statham	11:25	157
10 NHSE Annual Self-Certification	Frances Khatcherian/Caroline Lynch	11:40	163
11 Board Assurance Framework	Caroline Lynch	11:50	176
12 Corporate Risk Register	Katie Prichard-Thomas	11:55	192
13 Work Plan	Caroline Lynch		195
14 Date of Next Meeting: Wednesday 29 July 2026 at 09.00am			-

## Board of Directors

Wednesday 25 March 2026

09.00 – 11.55

Seminar Room, Trust Education Centre, Royal Berkshire Hospital

### Present

Mr. Oke Eleazu	(Chair)
Mr. Steve McManus	(Chief Executive)
Mr. Paul da Gama	(Chief People Officer)
Mr. Dom Hardy	(Chief Operating Officer)
Mr. Umesh Jetha	(Non-Executive Director)
Mrs. Frances Khatcherian	(Chief Finance Officer)
Dr. Janet Lippett	(Chief Medical Officer)
Mrs. Helen Mackenzie	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director)
Mr. Andrew Statham	(Chief Strategy Officer)
Prof. Parveen Yaqoob	(Non-Executive Director)

### In attendance

Ms. Jess Higson	(Deputy Chief Nursing Officer)
Mrs. Caroline Lynch	(Trust Secretary)

### Apologies

Dr. Minoo Irani	(Non-Executive Director)
Mr. Mike McEnaney	(Non-Executive Director)
Mrs. Katie Prichard-Thomas	(Chief Nursing Officer)

There were four Governors, four members of the public and six members of staff present.

### 35/26 Staff Story

The Chief Strategy Officer advised that, following the identification of the fire compartmentalisation issue in the Maternity, some services had to be moved or temporarily relocated within the building to enable the work to progress safely. Liz and Jill had managed the relocation of the Rushey ward. The move had been challenging for the team as the new location provided a smaller number of rooms for midwife-led care. Liz advised that Rushey ward had been moved to sit within the Delivery Suite and the Trust continued to provide Rushey Room, Delivery Suite, Theatre Births and Home birth services. The Board noted that between April 2025 to February 2026 there had been 4369 births, 175 of these were midwife-led and 78 home births. Since the move to the Delivery suite Since the move 27 women had had their baby with the Rushey team.

Jill provided an overview of the engagement undertaken to date that included staff briefings and updates. Key stakeholders such as Maternity & Neonatal Voices Partnership (MNVP), Healthwatch, Children centres and MPs had also been engaged. The Trust's website had been updated to set out Frequently Asked Questions (FAQs) in addition to a video of the interim Director of Midwifery explaining the changes. There had also been social media updates with responses provided to comments receive and midwives had been provided with information to

share with their patients. Ongoing engagement included attendance at a joint maternity partnership meeting to provide updates and answer questions as well as MNVP feedback questionnaire about the Rushey move and providing responses to queries raised.

The Board noted that the Rushey move had been completed in 4 days. It was also noted that the move was temporary and the team would be support as part of the major Master planning process. The Board thanked the team for the work in the relocation of the service and for their presentation.

### **36/26 Patient Story**

The Chief Medical Officer introduced Aubretia and Maya from the Research & Innovation (R&I) team and Mrs Gomes who had participated in a clinical trial. The team explained that the research team consisted of 5 research nurses and 2 research assistants and there were a number of specialities across the organisation involved in research and currently there were over 40 projects on-going. Mrs Gomes had been diagnosed in 2019 with focal segmental glomerulosclerosis (FSGS) and there was no approved pharmacological treatment specifically for FSGS so Mrs Gomes had agreed to enter into a clinical trial. The clinical trial was a randomised double-blind study to determine the long-term nephroprotective potential of treatment with Sparsentan. The research team had supported Mrs Gomes and having taken medication for 2 years her kidney condition had improved. During the investigations it had been identified that Mrs Gomes had a blocked heart artery and she had been treated for that. No issues had been identified at her last check in January 2026. The Board noted that Sparsentan was not approved by the Medicines and Healthcare products Regulatory Agency (MHRA) and the company provided the medication to Mrs Gomes free of charge.

The team explained that there were two patients originally entered into the study. However, one patient withdrew and they had not mentioned any past medical history and had taken ill during a bilateral exercise. The team identified that the patient had a pulmonary embolism and had treated him accordingly and saved his life. The Board noted that research active organisations resulted in better patient outcomes and better mortality rates.

The team explained that the Trust was one of 47 national sites for the Emergency Department blood borne virus opt out trial. The aim of the trial was to increase early detection of blood-borne viruses, identify undiagnosed patients, and reconnect those out of care to improve public health and support HIV elimination goals. From the trial 14 patients had been identified with HIV, 26 with Hepatitis C and 74 with Hepatitis B. As a result, these patients had an improved quality of life.

The team then provided an overview of the success of their key achievements and future focus.

Mrs Gomes explained that when she started the clinical trial she was concerned as, at that time, the drug had no name. However, as her condition had improved, she had continued and there had been no protein detected at her last appointment. The team explained that all tests carried out on patients during the study were funded by the company and there was no impact on the NHS services.

The Board thanked the team and Mrs Gomes for their story.

### **37/26 Minutes for approval: 25 March 2026 and Matters Arising Schedule**

The minutes of the meeting held on 25 March 2026 were agreed as a correct record and signed by the Chair.

The Board received the matters arising schedule. All actions had been completed.

## 38/26 Minutes of Board Committee Meetings and Committee Updates

### Audit & Risk Committee: 14 January 2026

The Board noted that the Committee had received the internal audit report on Patient Safety Incident Response Framework (PSIRF) one year after the implementation with a rating of 'partial assurance with improvement opportunities required'. Whilst there were a number of recommendations actions were either on-going or had been completed ahead of the report being issued. The Committee had also received the internal audit report on (Board Assurance Framework (BAF) rated as significant assurance with minor improvement opportunities'. The Committee had also reviewed the Standing Orders and recommended these for approval. The Committee had also received the annual effectiveness reviews of internal audit, external audit and counter fraud.

The Board noted that the Chair of the Audit & Risk Committee had rated the Cyber security update as 'partial assurance'. It was agreed that the Chief Operating Officer would discuss this rating with the Chair of the Committee. **Action: D Hardy**

The Committee had also received an update on internal audit recommendations and the Chair had rated this report as 'partial assurance' as confirmation that the estates project management actions had not yet been received.

At the March meeting the Committee had received its annual effectiveness review and terms of reference and recommended these for approval. The Board approved the terms of reference.

### Finance & Investment Committee: 21 January and 18 February 2026

The Chair of the Finance & Investment Committee advised that the Committee had recommended to the Board to approve £3.9m of Capital Departmental Expenditure Limit (CDEL) to ensure the emergency department expansion project could continue. However, once the Public Dividend Capital (PDC) had been received for the amount this would be transferred back to CDEL. The Trust had also received cash support in January 2026.

At its February meeting the Committee had noted that financial performance was slightly behind plan. A cash forecast had been reviewed and the full capital programme was submitted to the March meeting.

The Chair of the Finance & Investment Committee advised that at the March meeting financial performance was on plan. A total of £21m of the 2026/27 efficiency programme had been identified. The Committee had also reviewed and recommended the draft budget for 2026/27 for approval although discussions with commissioners were still on-going. The Committee had also reviewed and recommended the capital programme for 2026/27 for approval. The Committee had also reviewed and recommended its annual review of effectiveness and terms of reference for approval. The Board approved the terms of reference.

### Quality Committee: 2 February 2026

The Chair of the Quality Committee alerted the Board that there was one potential high risk inquest related to trauma and orthopaedics/care of the elderly. Two Never Events had been declared in gynaecology and ophthalmology and there had been only minimal harm. The Committee had noted that the C.Diff. target had been breached although it was assured on actions being taken.

The Chair of the Quality Committee advised that there had been an increase in perinatal mortality in Quarter 3, although these were small numbers, a review was in progress and the

outcome would be submitted to the next meeting. Call 4 Concern implementation was continuing and the use of the service was positive with an increase in the number of calls noted. In relation to PSIRF, there had been 3 patient safety investigations, 2 Never Events and 58 rapid reviews, 51 after action reviews and 7 multidisciplinary reviews undertaken.

The Board noted that a review of complaints had been completed and actions from the review were in progress. However, whilst complaint response times were improving further work was required. The general theme for complaints was communication. However, it had been noted that the Trust was receiving more Artificial Intelligence (AI) generated complaints. The complaints team would be supported with improved software to achieve quicker response times. The Committee had been assured by the actions taken from the complaints review.

The Committee had also received the Home Birth report and, following the issue of a Regulation 28 Prevention of Future Deaths (PFD) to another trust the Committee had received good assurance that the Trust met the Home Birth standards. The Committee had also received assurance on Emergency Department (ED) performance and the national hip fracture database audit.

The Board noted that the Chair of the Quality Committee and the Chief Nursing Officer had reviewed the evidence for the Maternity Incentive Scheme (MIS) and had recommended that the Chief Executive should sign the declaration.

The Chair of the Quality Committee highlighted that Structured Judgement Reviews (SJRs) were graded as either 1 or 2 according to whether there had been any lapses in care and whether this had affected the outcome. Whilst there had been some Grade 2s this was not a trend and the learning had been shared via the local clinical governance meetings for cascade. There had previously been some concerns regarding the timely completion of SJRs and support had been put in place. An internal audit had been commissioned for 2026/27 on the SJR process.

#### People Committee: 20 February 2026

The Chair of the People Committee advised that the Committee had received positive assurance on a number of items discussed at the February meeting. This included preparations by the Trust to ensure that Mandatory & Statutory Training (MAST) was more outcome focused in line with national directives, the positive 2025 staff survey results and the 10 point plan to improve Resident Doctors working lives. The Committee had reviewed the Gender Pay Gap report and had considered that partial assurance had been received as there continued to be a 'representation gap' in female representation in the top pay quartile relative to female representation overall in the Trust. The Chief People Officer advised that the pay gap was almost entirely due to more senior consultants being male rather than female, although this was a trend that was beginning to change. For example, the Trust had appointed more female than male consultants in the previous year.

The Committee had also received its annual effectiveness review and recommended its terms of reference for approval. The Board approved the terms of reference.

#### Charity Committee: 4 March 2026

The Chair of the Charity Committee advised that the Committee had received positive assurance on the work of the Charity and its planning for the 30<sup>th</sup> anniversary. The Committee had discussed the need to increase charitable monies received as well as the use of an

investment house for it reserves. A charity workshop was scheduled and a further update on the future Charity strategy would be submitted to the Board in May 2026. **Action: J Lippett**

The Board considered that the use of the Chair Assurance reports developed as part of the Board's improvement huddle were a welcome addition.

The Committee had also reviewed its terms of reference and recommended these for approval. The Board approved the terms of reference.

### **39/26 Chief Executive's Report**

The Chief Executive introduced the report and advised that the Trust valued the diversity of its staff groups and community and due to the recent events in the Middle East, the chaplaincy team were holding a monthly candle-lit vigils as these events were unsettling for both staff, volunteers and service users.

The Chief Executive highlighted the national approach in relation to oversight and targeted support to NHS organisations that were in segment 5 of the National Oversight Framework (NOF). The Trust's Quarter 3 position for 2025/26 had now been validated and the Trust had been placed in segment 3. As the underlying score had improved slightly, the Trust's position in the acute league table was 28 out of 134. Excluding the Trust's financial position the Trust would be 6 out of 134.

The Chief Executive thanked the nuclear medicine and corporate nursing team for their efforts as the Care Quality Commission (CQC) had removed the improvement notice following their Ionising Radiation [Medical Exposure] Regulations (IR[ME]R re-inspection. The Chief Executive also thanked all the teams involved in relation to maternity building relocation exercise including the estates and facilities team for their work to mitigate the issues. The Trust had also worked closely with the Royal Berkshire Fire & Rescue Services (RBFRS) who issued two enforcement notices to the Trust although the first one had since been removed and this provided positive assurance to the Board.

The Board noted that 600 nominations had been received for the CARE awards. There were 12 categories of awards and Care Group leaders and members of the Board would be reviewing the nominations ahead of the ceremony on 15 May 2026.

The Chief Executive highlighted that the Chief Finance Officer had been appointed from March 2026 and the new Chief Executive, James Blythe, would be taking up his role on 18 May 2026 although James was already spending time at the Trust meeting various teams.

The Board noted that the Health Innovation Partnership (HIP) with the University of Reading had been renamed as the Reading & Thames Valley Health Innovation Partnership following an evaluation of the partnership. The Chief Executive highlighted that the University of Reading had held an event to celebrate the 100 years since it was presented with its Charter of Incorporation from King George the fifth and became a University in its own right. The Chief Executive, on behalf of the Trust, had received the Community Pledge from the Chancellor of the University. The Trust continued to value its relationship with the University of Reading and support its ambition for the next 100 years.

The Board noted that the ED expansion project was due for completion by the end of March 2026 and the LINAC bunker and control room within the radiotherapy department at the Royal Berkshire Hospital had been refurbished. The installation was completed successfully and removal of the Bracknell LINAC was scheduled for the weekend of 28 March 2026 as part of enabling works for the new LINAC at that location. The Chief Executive acknowledged the work of the estates and operational teams on both projects that would improve the equipment and facilities for both patients and staff.

The Board noted that the Same Day Emergency Care (SDEC) facility was currently based in the short-stay area and a designated dedicated reception for SDEC would be created adjacent to ED. This would be provide improved joint working between ED and SDEC teams.

The Chief Executive advised that the Trust had worked hard throughout the year to deliver against all aspects of its financial plan, including a deficit of no more than £7.8m. As the year-end approached there was confidence that underlying performance was in line with plan. However, the Trust has recently identified a significant income issue, primarily relating to the treatment of prior year accruals. This was being discussed with the Integrated Care Board (ICB) and NHS England (NHSE) and this could impact on the 2025/26 position.

The Chief Executive advised that the Trust submitted its operational plan on 18 March 2026 with an income gap of £11.2m. This had been recognised by both the ICB and NHSE.

In response to a query regarding the recent issue of meningitis the Chief Medical Officer advised that clear guidance had been circulated to teams including ED and Primary Care.

#### **40/26 Integrated Performance Report (IPR)**

The Chief Medical Officer introduced the IPR and highlighted that the Friends & Family Test (FFT) score for patients feeling listened to and well-informed was 93.5% against a target of 95%. The Chief Medical Officer highlighted that the recent changes introduced such as removal of leaflets advertising FFT in the maternity building could inadvertently worsen the response rate. Further targeted actions were being undertaken, including focused feedback to low-response areas and the recruitment of a Non-Executive Director with relevant patient experience expertise.

Incident reporting had recently increased slightly. There were no new alerting watch metrics this month although there had been an increase in perinatal mortality in Quarter 4 2025/26. Mixed sex accommodation breaches had reduced although these remained high. These were due to capacity challenges particularly at twilight and overnight.

The Chief Medical Officer advised that the stability metric remained positive supported by the strong staff survey results and there had been good progress in the percentage of global majority staff in senior roles.

Emergency Department (ED) performance remained challenged through the winter period, with increased attendances of Flu and Covid. Overall, there had been a 9% year-on-year increase in overall activity despite a national planning assumption of zero growth. Data had been reviewed in relation to attendance patterns and 75.4% had been achieved in February 2026 and the Trust continued to work with partners in the system. Length of stay had increased slightly for non-elective patients and actions included strengthening the use of the discharge lounge and improved accuracy of targeted discharge date data. The Chief Operating Officer highlighted length of stay was critical to both patient experience and care and the conversion rate from ED attendances remained consistent. The Board discussed the 78% trajectory for March 2026. The Chief Operating Officer advised it was anticipated that the Trust would be close to this target and areas of improvement in ED performance were evident in the IPR.

The Chief Medical Officer highlighted the national 'sprint event' in relation to improving corridor care in the NHS. The Trust did not provide corridor care although use of temporary escalation spaces would meet the NHS definition and it was expected that the Trust may have a small number to report in busy periods.

The Chief Medical Officer advised that the Trust was on target to achieve the 62 day cancer standard. 18 week Referral to Treatment (RTT) performance was just below the national standard although the trajectory had been met and DM01 performance demonstrated an upward trajectory.

The Board noted that distance travelled by patients in February 2026 was 4.8 miles. In addition, the Trust was on target to achieve the 2025/26 cost improvement programme and productivity was on target. There had been a robust discussion at the Finance & Investment Committee in relation to Month 11 financial performance.

The 'Do Not Attend' (DNA) rate for the musculoskeletal service was high and the opt-in process for booking MSK physiotherapy appointments has been extended to the entire physiotherapy service for routine appointments.

The Chief Executive highlighted that, overall, the IPR demonstrated the on-going balance of quality, access standards versus financial position and resources. The Trust had a challenging year ahead in relation to cost improvement and it was important that the Board remained alert to a potential impact on performance standards.

#### **41/26 Integrated Performance Report Metrics Review**

The Chief Operating Officer highlighted that the IPR metrics were reviewed on an annual basis. The National Oversight Framework (NOF) metrics were reflected throughout the IPR although following engagement with both the Board and Executive Management and Operational Management committees, it had been agreed that three NOF metrics that were not currently in the IPR would be added as watch metrics: Readmission rate band, Percentage of inpatients referred to in-house tobacco treatment services who make a supported attempt to stop smoking and Under 18s elective waiting list growth.

The Chief Operating Officer advised that the Digitally enabling our patients: % of patients accessing patient portal / NHS app strategic metric would be adapted over time. The implementation of the strategic programmes would enable metric to be included in the IPR. In addition, Committees could also escalate metrics for inclusion in the IPR.

The Chief Executive highlighted that the IPR metrics were aligned with the Improving Together architecture. The Chief Operating Officer advised that work was currently on-going with the Care Groups to refresh their driver metrics and this was an iterative process which would ensure alignment across the organisation. The Board noted the feedback received during the engagement exercise to review the IPR metrics.

#### **42/26 2025 Staff Survey Results**

The Chief People Officer introduced the report and highlighted the Trust's strong performance, both in terms of response rates and overall engagement scores. The Trust achieved a response rate of 62%, significantly above the national average of 47%. Performance had improved across 8 of the 9 People Promise themes and 19 of the 21 sub-themes. This was particularly encouraging given that the overall national trend for 2025 indicated a deterioration in staff experience across the NHS. However, some areas of decline were noted, including increased reports of negative and aggressive behaviours from patients, alongside concerns relating to career development opportunities.

It was confirmed that the Executive Management Committee (EMC) would receive an overview of the actions being taken to address key areas requiring improvement in April 2026. All divisions and departments had now received their local results, and reviews had been undertaken in areas with lower engagement scores, with local action plans currently being developed.

Whilst the overall position was viewed positively, it was acknowledged that the significant financial and operational pressures facing the Trust could potentially adversely impact future staff survey results. The Chief Executive emphasised the importance of acting purposefully and at pace on the findings from the 2025 Staff Survey, highlighting that the 2026 survey would launch in just 153 days' time.

**43/26 Work Plan**

The Board received the work plan.

**44/26 Date of Next Meeting**

It was agreed that the next meeting would be held on Wednesday 27 May 2026 at 09.00

The Chair, on behalf of the Board, thanked the Chief Executive as this would be his last public Board meeting, as he was stepping down from his role after nearly 10 years, during May 2026. The Chair highlighted that the Chief Executive had created a culture in the Trust where people felt heard and valued hence the increasing improved staff survey results.

The Chair also thanked Parveen Yaqoob as this was her last public Board meeting as she would be stepping down from her role at the end of March 2026. The Chair thanked Parveen for her insight during her 3 year term of office.

**SIGNED:**

**DATE:**

**Public Board of Directors Matters Arising Schedule**

**Agenda Item 4**

<b>Date</b>	<b>Minute Ref</b>	<b>Subject</b>	<b>Matter Arising</b>	<b>Owner</b>	<b>Update</b>
25 March 2026	38/26	Minutes of Board Committee Meetings and Committee Updates: Audit & Risk Committee: 14 January 2026	The Board noted that the Chair of the Audit & Risk Committee had rated the Cyber security update as 'partial assurance'. It was agreed that the Chief Operating Officer would discuss this rating with the Chair of the Committee.	D Hardy	Outstanding.
25 March 2026	38/26	Minutes of Board Committee Meetings and Committee Updates: Charity Committee: 4 March 2026	A charity workshop was scheduled and a further update on the future Charity strategy would be submitted to the Board in May 2026.	J Lippett	Completed. Item on the private Board agenda.

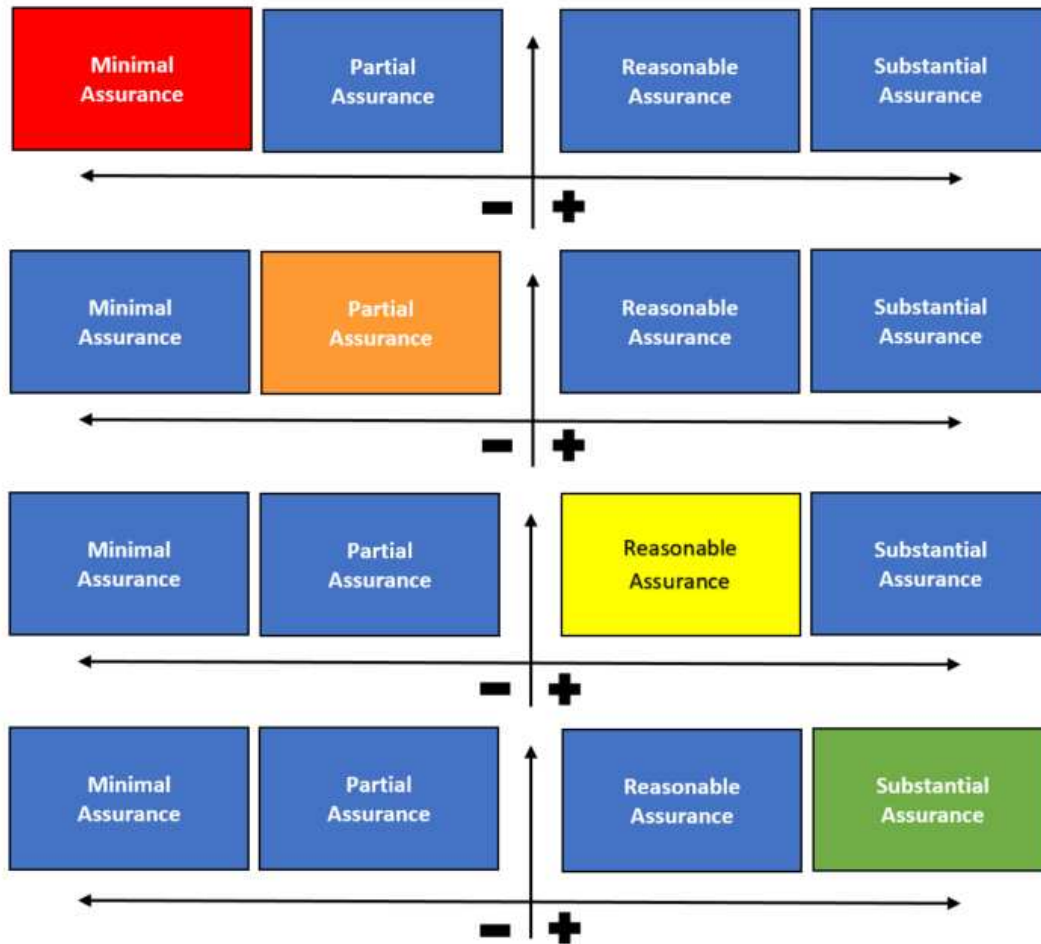
# Audit & Risk Committee Chairs Report

Committee Chair: Mike McEnaney

11 March 2026	
Agenda Item 4: Local Counter Fraud Progress Report	Substantial Assurance
Agenda Item 5: External Audit Progress Report	Reasonable Assurance
Agenda Item 6.1 Internal Audit Plan 2026/27	Substantial Assurance
Agenda Item 7: Internal Audit Recommendations	Reasonable Assurance
Agenda Item 12: NHS Code of Governance Review	Substantial Assurance

11 March 2026	
Agenda Item 8: DDaT Risk Register	Partial Assurance
Agenda Item 12: NHS Code of Governance Review	Substantial Assurance
Agenda Item 13: Committee Effectiveness and Terms of Reference	Substantial Assurance

<p><b>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)</b></p> <ul style="list-style-type: none"> <li>None</li> </ul>	<p><b>MAJOR ACTIONS AGREED (ADVISE)</b></p> <ul style="list-style-type: none"> <li>Further actions requested to finalise DDaT Risk Register</li> </ul>
<p><b>POSITIVE ASSURANCES TO PROVIDE (ASSURE)</b></p> <ul style="list-style-type: none"> <li>External Audit Plan on track.</li> <li>Good progress in completing outstanding internal audit review recommendations</li> <li>High level of Compliance with NHS Code of Governance</li> </ul>	<p><b>DECISIONS MADE (APPROVE)</b></p> <ul style="list-style-type: none"> <li>Counter Fraud and Internal Audit Plans for 2026/27 approved.</li> <li>Recommendation to the Board to approve Committee Effectiveness Review and Terms of Reference</li> </ul>



Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.

There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.

There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.

There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

## Audit & Risk Committee

### Audit & Risk Committee

Wednesday 11 March 2026

9.30 – 11.00

Boardroom, Level 4

#### Members

Mr. Mike McEnaney (Non-Executive Director)

Mr. Mike O'Donovan (Non-Executive Director)

Mrs. Helen Mackenzie (Non-Executive Director)

#### In attendance

##### Advisors

Mr. James Shortall (Local Counter Fraud Specialist) (LCFS)

Mr. Neil Thomas (Partner, KPMG)

Mr. Stephen Turner (Partner, Deloitte)

Mr. Sam Williams (Manager, Deloitte)

##### Trust Staff

Mr. Mike Clements (Deputy Director of Finance)

Mr. Dom Hardy (Chief Operating Officer) (up to minute 35/26)

Mrs. Frances Khatcherian (Chief Finance Officer)

Mrs. Caroline Lynch (Trust Secretary)

Ms. Katie Prichard-Thomas (Chief Nursing Officer)

#### Apologies

Mr. Umesh Jetha (Non-Executive Director)

#### 27/26 Declarations of Interests

There were no declarations of interest.

#### 28/26 Minutes for approval: 14 January 2026 and Matters Arising Schedule

The minutes of the meeting held on 14 January 2026 were agreed as a correct record and signed by the Chair.

The Committee received the matters arising schedule.

Minute 02/26 (105/25 (83/25, 25/25, 02/25, 113/24): Minutes for approval: 21 November 2024: HFMS Ltd Annual Report & Accounts 2023/24: The Committee noted that the HFMS Governance review had not yet been issued to the Trust. The Trust Secretary advised that the review would need to be reviewed by HFMS Board prior to submission to the Committee in May 2026.

#### 29/26 Local Counter Fraud Progress Report

The Local Counter Fraud Specialist (LCFS) advised that plan for 2025/26 was near completion. In relation to the local proactive exercise to anomalies and outliers within

overtime claims, work was ongoing to review the top 10 earners with payroll in additional to shifts works versus contracts and job plans.

### **30/26 Local Counter Fraud Annual Plan 2026/27**

The LCFS introduced the annual plan for 2026/27. Proactive work included expense claims as well as use of the Trust's credit cards. The Chief Finance Officer suggested it would be used to discuss the planned proactive work with the Executive team. **Action: F Khatcherian**

The LCFS highlighted fraud training and awareness and advised that 176 staff had received specific fraud training, for example, those staff that worked in high risk areas such as estates, digital, payroll, finance and procurement. It was agreed that the LCFS would share the national procurement exercise with the Committee. **Action: J Shortall**

The Committee approved the Counter Fraud plan for 2026/27.

### **31/26 External Audit Progress Report**

The Partner, Deloitte, advised that the level of materiality for the year-end audit would be consistent with the previous year. Accruals had presented a significant risk previously although this had not been reduced. Other areas of focus included property evaluation. The Partner, Deloitte, highlighted that value for money would be highlighted by the audit due to the financial sustainability risk for the organisation. Currently the year-end audit was on plan.

The Manager, Deloitte, advised that planning work had been completed in addition to the interim work on Month 9. An area of focus would be the delay in revenue once Month 11 had been closed although it was noted that revenue agreement with commissioners had not yet been achieved. Three areas of focus for the year-end audit included property valuation, significant fraud risk, for example, capital expenditure as well as manual override of controls. The Committee noted that the Trust had informed external audit that there would be some vesting certificates at year end in relation to the West Berkshire Community Hospital (WBCH) project. The Manager, Deloitte, highlighted that Task Force on Climate-Related Disclosures (TCFD) would also be an area of focus as this had been an issue in the previous audit.

The Committee noted that the Annual Report Manual (ARM) guidance had now been published and the Trust Secretary would be meeting with the Senior Manager, Deloitte, to review the changes in order to share with those staff contributing to the Annual Report.

### **32/26 Internal Audit Progress Report**

The Partner, KPMG, introduced the report and advised that the access and activity audit had been delayed although time had been scheduled to finalise the report being issued. The data security and protection toolkit (DSPT) review was on-going. The Committee noted that the access report had been issued in October 2025. However, the Digital, Data & Technology (DDaT) had operational pressures and there had been delays in the terms of reference for the review being approved. The Committee recommended that standard key performance indicators (KPIs) should be developed for response times from management and this should be included in future reports. **Action: N Thomas**

### **33/26 Internal Audit Plan 2026/27**

The Partner, KPMG, advised that discussions had been held with the Chief Executive team and other key staff to discuss the plan for 2026/27. The plan had also been submitted to the Executive Management Committee, discussed with members of the Committee and aligned with the Corporate Risk Register.

The Committee noted that a procurement review would be scheduled for 2027/28.

The Committee approved the internal audit plan for 2026/27.

### **34/26 Internal Audit Recommendations**

The Chief Finance Officer introduced the report and highlighted that there were 15 overdue actions, 14 of which relates to the estates review. Actions from the review had been completed and were awaiting review by the internal audit team.

The Chief Finance Officer advised that the actions from the finance function review had been added to the JIRA system and the majority were completed. The actions from the external audit review had not yet been added and an update would be provided at the next meeting.

**Action: F Khatcherian**

The Partner, KPMG, would confirm that the estates recommendations had been completed.

**Action: N Thomas**

### **35/26 Digital, Data & Technology (DDaT) Risk Register**

The Chief Operating Officer introduced the risk register and advised that this required review by the Integrated Risk Management Committee (IRMC). The Committee noted that the risks had not been recently reviewed and the risk register would also be reviewed by the Digital Hospital Committee. The Committee recommended that the target risk ratings should be reviewed to ensure they were feasible in addition to ensure mitigations as well as a timeline for actions was included.

**Action: D Hardy**

The Chief Operating Officer advised that the Head of Risk was currently working with the DDaT team to provide support on use of the Datix system. The Chief Nursing Officer confirmed that escalation report templates were being developed for Care Groups and corporate areas, including DDaT, and further information would be included as part of the next Corporate Risk Register update.

**Action: K Prichard-Thomas**

### **37/26 Use of Single Tenders**

The Committee noted that 8 single tender waiver (STW) contracts had been awarded from 1 January 2026 to 28 February 2026. The Chief Finance Officer advised that some of these related to last minute capital allocations as a result of late notifications from NHS England (NHSE). It was agreed that the Chief Finance Officer would confirm the percentage total spend of STWs for the period.

**Action: F Khatcherian**

In addition, future reports would set out the specific reason for the use of a STW.

**Action: F Khatcherian**

### **38/26 Use of Significant Contracts**

The Committee noted that six significant contracts had been awarded since the last meeting as follows:

- Trustmarque Solutions Limited 3 year contract £1,372,534.41
- 18 Week Support Ltd 6 months contract £195,480.00
- Xerox 3 year + 1 year optional extension £1,460,160.00
- Everlight Radiology 6 years + 1 year optional extension
- Intelrad Medical Systems 1 year contract £344,138.37

- Ultima Business Solutions 1 year contract £3,178,707.96

> The Committee noted that three significant contracts had been awarded since the last meeting

### **39/26 Bank Account Authorisations**

The Committee noted that there had been no amendments to the Trust of the Royal Berks Charity signatory panel since the last meeting.

### **40/26 Non-NHS Debt Report**

The Committee noted that non-NHS debt was £8.3m as at 28 February 2026. The committee noted the cash collection profile in relation to overseas debt. The Director of Finance advised that there had been an increase in the level of overseas activity. In addition, there were external factors that impacted rules for vulnerable groups. The Chief Nursing Officer advised that the Trust had undertaken significant engagement with community partners in relation to overseas patients. The Director of Finance advised that work was on-going to re-establish communications with the organisation to ensure all areas were aware of the rules in relation to those patients that were required to pay for treatment.

### **41/26 NHS Code of Governance Review**

The Trust Secretary introduced the draft report and advised that further work was on-going to complete the review to inclusion in the Annual Report. Currently, the Trust was compliant with 85 out of 89 provisions that were applicable to foundation trusts. The Trust would include an 'explain' narrative for those provisions that could not be deemed as 'compliant'.

### **42/26 Review of Committee's Effectiveness & Terms of Reference**

The Trust Secretary introduced the annual review of effectiveness and terms of reference. The Committee agreed that a recommendation should be submitted to the Board to approve the effectiveness review and terms of reference. **Action: M McEnaney**

### **43/26 Work Plan**

The Committee received the work plan for 2026.

### **44/26 Key Messages to the Board**

It was agreed that key issues to draw to the attention of the Board included:

- Approval of the Counter Fraud plan for 2026/27
- Approval of the Internal Audit plan 2026/27
- Good progress achieved on the internal audit recommendations
- Good progress achieved on the External Audit plan for 2025/26
- DDaT risk register reviewed with recommendations made regarding timeline and mitigating actions
- Code of Governance review received
- Recommendation to approve the Committee's effectiveness review and terms of reference

### **46/26 Reflections of the Meeting**

The Trust Secretary led the discussion.

**47/26 Date of Next Meeting**

It was agreed that the next meeting would take place Wednesday 13 May 2026 at 9.30am.

**48/26 Private Meeting with Internal Audit**

A private meeting with KPMG was not held.

**49/26 Private Meeting with External Audit**

A private meeting with Deloitte was not held.

**50/26 Private Meeting of the Committee**

A private meeting of the Committee was not held.

**Chair:**

**Date:**

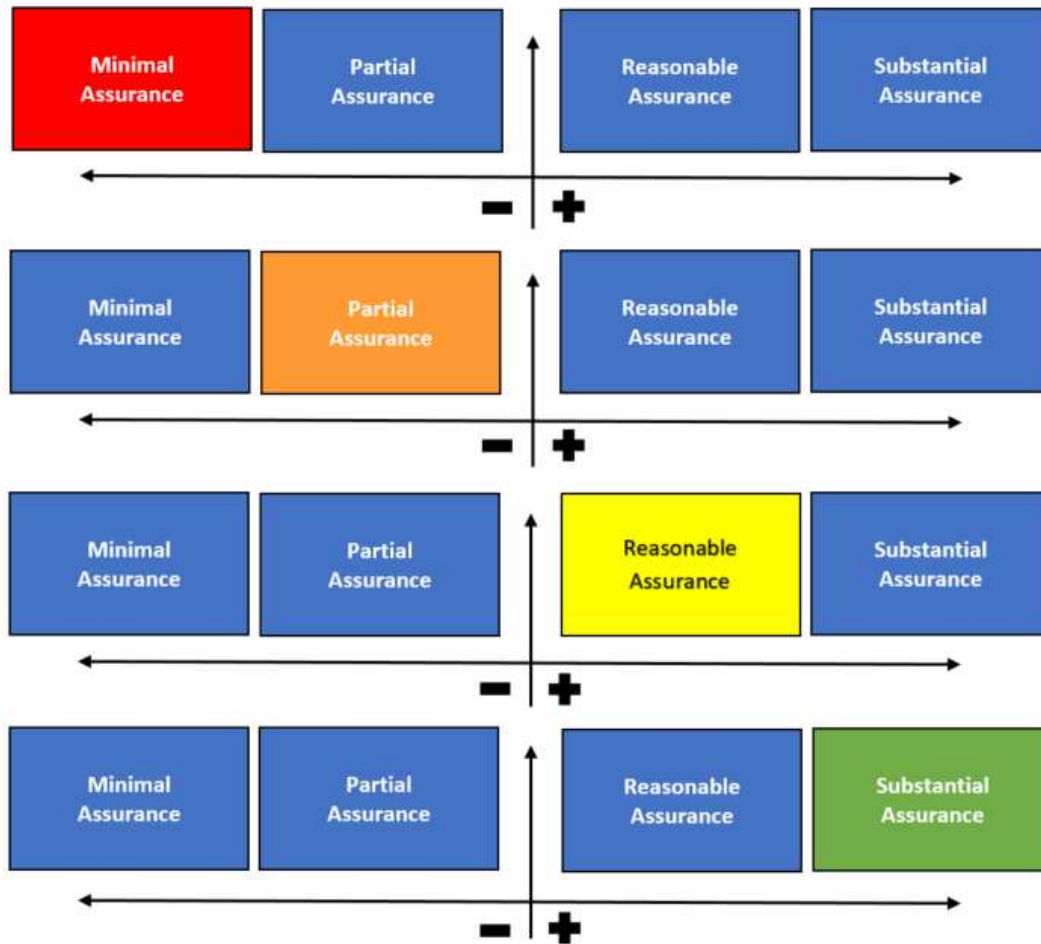
# Finance and Investment Committee Chairs Report

**Committee Chair:** Mike O'Donovan

## 18 March 2026

Agenda Item 3: Month 11 Finance Report	<b>Substantial Assurance</b>
Agenda Item 3: Month 11 Finance Report – 2024/25 Income Position	<b>Partial Assurance</b>
Agenda Item 5: Draft Budget 2026/27	<b>Reasonable Assurance</b>
Agenda Item 6: Capital Programme Update 2026/27	<b>Reasonable Assurance</b>

<p><b>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)</b></p> <ul style="list-style-type: none"> <li>Income accrual error from 2024/25</li> </ul>	<p><b>MAJOR ACTIONS AGREED (ADVISE)</b></p> <ul style="list-style-type: none"> <li>Draft Budget for 2026/27 recommended for approval</li> <li>Draft Capital Programme 2026/27 recommended for approval</li> </ul>
<p><b>POSITIVE ASSURANCES TO PROVIDE (ASSURE)</b></p> <ul style="list-style-type: none"> <li>Month 11 on plan</li> </ul>	<p><b>DECISIONS MADE (APPROVE)</b></p> <ul style="list-style-type: none"> <li>None</li> </ul>



Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.

There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.

There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.

There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

## Finance & Investment Committee Part I

Wednesday 18 March 2026

9.30 – 10.45

Boardroom, Level 4, Royal Berkshire Hospital

### Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Mrs. Frances Khatcherian	(Chief Finance Officer)
Dr. Janet Lippett	(Chief Medical Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Andrew Statham	(Chief Strategy Officer)

### In Attendance

Mr. Paul da Gama	(Chief People Officer) (up to minute 38/26)
Mr. Oke Eleazu	(Chair of the Trust)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)
Mrs. Tara Whittington	(Head of Corporate Governance)

### 34/26 Declarations of Interest

There were no declarations of interest.

### 35/26 Minutes for Approval: 18 February 2026 & Matters Arising Schedule

The minutes of the meeting held on 18 February 2026 were approved as a correct record and signed by the Chair.

The Committee received the matters arising schedule. All actions had been completed.

### 36/26 Month 11 Finance Report including Financial Improvement Plan 2025/26

The Committee noted that the Trust had identified a significant income accrual error relating to 2024/25, whereby a 2024/25 income provision had remained on the balance sheet, resulting in a £12.9m year-end misstatement. As a result, the 2024/25 opening position appeared £12.9m higher than it should have been.

The Chief Finance Officer reported a further issue in 2024/25 relating to income accrued within the year-to-date forecast outturn, which could result in a £6m clawback. NHS England (NHSE) had initially indicated that the depreciation impact could be offset via an allocation to the Integrated Care Board (ICB). However, this support was now at risk following the earlier misstatement.

The Chief Finance Officer outlined three potential financial scenarios: both income issues crystallising in-year, resulting in a £26.7m deficit (£19.1m adverse to plan); NHSE offsetting both issues via an allocation to the ICB, resulting in a position closer to plan; or NHSE

declining support and removing Quarter 4 Deficit Support Funding (DSF) of £3.3m, resulting in a £30m deficit (£22.2m adverse to plan).

The Committee noted that immediate actions taken included a review of Finance team responsibilities, engagement with the NHS Counter Fraud Authority, internal audit involvement, support from the NHSE South East Finance Director, and an internal investigation.

The Chief Finance Officer highlighted that other system partners could also potentially forfeit their DSF, although this had not yet been confirmed.

The Committee noted that both issues were non-recurrent and would not affect 2026/27 plans. The Chief Finance Officer advised that the most likely outcome would be repayment of c.£30m over three years. It was confirmed that, although the deficit position would be impacted, there was no immediate cash impact and the Trust could apply for additional cash support. The Trust had recently applied for the final tranche of the £18.93m cash application submitted in December 2025.

The Committee discussed the potential reputational impact with system partners. The issue could affect the Trust's National Oversight Framework (NOF) rating.

It was agreed that the Trust would need to clearly explain the income accrual issue to staff, particularly in light of the significant effort in delivering cost improvement programmes, and that an appropriate narrative should be included in the Chief Executive's report to the March Public Board.

The Chief Finance Officer reported that the Trust had delivered its year-to-date plan at Month 11, although activity underperformance of £4.18m remained. Income was £12.36m ahead of plan. Pay was £7.61m adverse to plan and net drugs expenditure was £7.66m adverse to plan.

Month 11 financial recovery actions had been delivered, though continued improvement across all Care Groups and corporate directorates was required to achieve the planned year-end deficit. Discussions with commissioners on expected income were being finalised to provide greater certainty on full year activity income and drugs income.

The Committee noted that the Trust remained aligned to the Month 11 forecast established at Month 6, and Care Groups and most Corporate Services were operating within their action plans.

The Trust had delivered 79.7% of the £40.60m efficiency target year-to-date. Corporate directorates continued to overperform against their action plans, providing assurance of delivery of the full-year financial plan.

The Chief Finance Officer advised that there had been a net increase of 33 whole time equivalents (WTE) in Month 11 compared to Month 10, including 26 substantive posts, resulting in substantive staffing of 219 WTE above the original plan. Urgent action was required to reduce WTE levels to support delivery of the year-end position. Workforce control measures were under review, including recruitment deceleration, the launch of the Mutually Agreed Redundancy Scheme (MARS) and increased scrutiny of vacancies held for more than eight months.

The Committee noted that, although delivery of the plan remained challenging, there was potential for improvement in Month 12 through increased activity and the possible release

of Trust-held provisions. Regional and national discussions in relation to depreciation funding were ongoing and could provide further support to the year-end position.

The Chief Finance Officer reported that although the Trust had a £3m provision from Buckinghamshire, Oxfordshire and Berkshire (BOB) ICB, a £1.2m clawback was expected following performance reconciliation.

The Committee noted a gap on the closing month-end cash position for Month 11 and the forecast cash position. The Chief Finance Officer would review and correct the figures.

**Action: F Khatcherian**

### **37/26 Financial Improvement Plan 2026/27**

The Committee noted that as at February 2026, the Trust had identified £21.27m; 49.8% of the £43.70m efficiency and productivity savings plan for 2026/27.

### **38/26 Draft Budget 2026/27**

The Chief Finance Officer reported that a compliant plan was submitted to NHSE on 12 February 2026 that included contract misalignments due to the difference between commissioner expenditure assumptions and the Trust's income expectations.

The Chief Finance Officer reported that the Trust had received £3.9m from the Thames Valley ICB Innovation Fund to support elective referral to treatment (RTT). Commissioners had also proposed £8m of additional growth funding, including £4.4m for non-elective growth and £0.75m for high-cost drugs. Other commissioner income offers had improved the income position by a further £1.4m.

The Committee noted that these improvements were offset by the removal of £5.7m of assumed depreciation funding, resulting in a net income uplift of £7.5m. This uplift was below the Trust's original request to Thames Valley ICB and required careful prioritisation of resources in 2026/27 to meet operational performance standards.

The Chief Finance Officer highlighted risks including contract and planning assumptions remaining subject to change until formally agreed with NHSE, data quality issues in relation to the capture of patient activity; and an underlying cost base higher than planned, resulting in a significant efficiency requirement for 2026/27.

The Committee approved the recommendation to accept the system proposal to plan for a deficit of £11.2m for 2026/27 whilst continuing discussions with partners to improve the position.

The Committee also approved the recommendation to set expenditure budgets aligned to new income allocations to be implemented from April 2026.

The Committee requested that a risk and opportunities schedule should be submitted to future meetings to enable risks to be monitored throughout the year. The Chief Finance Officer agreed that this would be provided on a quarterly basis. **Action: F Khatcherian**

### **39/26 Capital Programme Update 2026/27**

The Chief Finance Officer introduced a 5-year capital plan including 2026/27 in detail and an outline of the plan for 2027 to 2031. It was proposed for 2026/27 a total Capital Departmental Expenditure Limit (CDEL) allocation of £39.1m (plan £35.6m with additional 10% stretch) was proposed. £28.6m of the £39.1m CDEL total would be allocated to a core

plan. £1m from the core plan would be allocated to Care Groups for low-cost, high-value projects

The CDEL balance of £10.5m would be held for 'strategic' capital expenditure, yet to be prioritised. The Committee discussed whether elements of this should be considered for estates backlog maintenance as this was a high rated risk on the Corporate Risk Register.

The Trust anticipated that £3m of Public Dividend Capital (PDC) would be available annually from the Estates Safety Fund for a minimum of four years and that this would be added to operational estates funding.

The Trust had also allocated £10.5m for the expansion of the emergency department, in 2026/27, for which a business case would be submitted to NHSE following Board approval. This would be submitted to the Committee at a future date. **Action: D Hardy**

The Committee agreed that a recommendation should be submitted to the Board to approve £28.6m of operational capital expenditure for 2026/27. In addition, a recommendation would be submitted to the Board that an annual expenditure of £3m of PDC from the estates safety fund, would be allocated to operational estates funding.

The Committee agreed that a recommendation would be submitted to the Board that the capital programme for 2026/27 could be amended in the event that remedial works to the maternity block were considered essential and could not be funded through the estates multi-year allocation or the estates safety fund. In addition, a recommendation that the capital programme for 2026/27 could be paused in the event the Trust was not delivering the agreed income and expenditure plan and as a consequence could not access revenue cash support. **Action: M O'Donovan**

#### **40/26 Key Messages for the Board**

Key messages for the Board included:

- A significant income accrual error from 2024/25 had been identified with a range of potential impacts on the Trust's declared deficit for 2025//26. NHSE had been briefed and internal and external investigations had begun
- Month 11 financial plan on target to achieve the planned 2025/26 budget deficit.
- Recommendation to approve the proposal draft budget 2026/27
- Recommendation to approve CDEL core plan for 2026/27 of £28.6m
- Recommendation to approve the annual capital expenditure of £3m PDC from the Estates Safety Fund

#### **41/26 Date of Next Meeting**

It was agreed that the next meeting would take place on Wednesday 15 April 2026 at 9.30am.

**SIGNED:**

**DATE:**

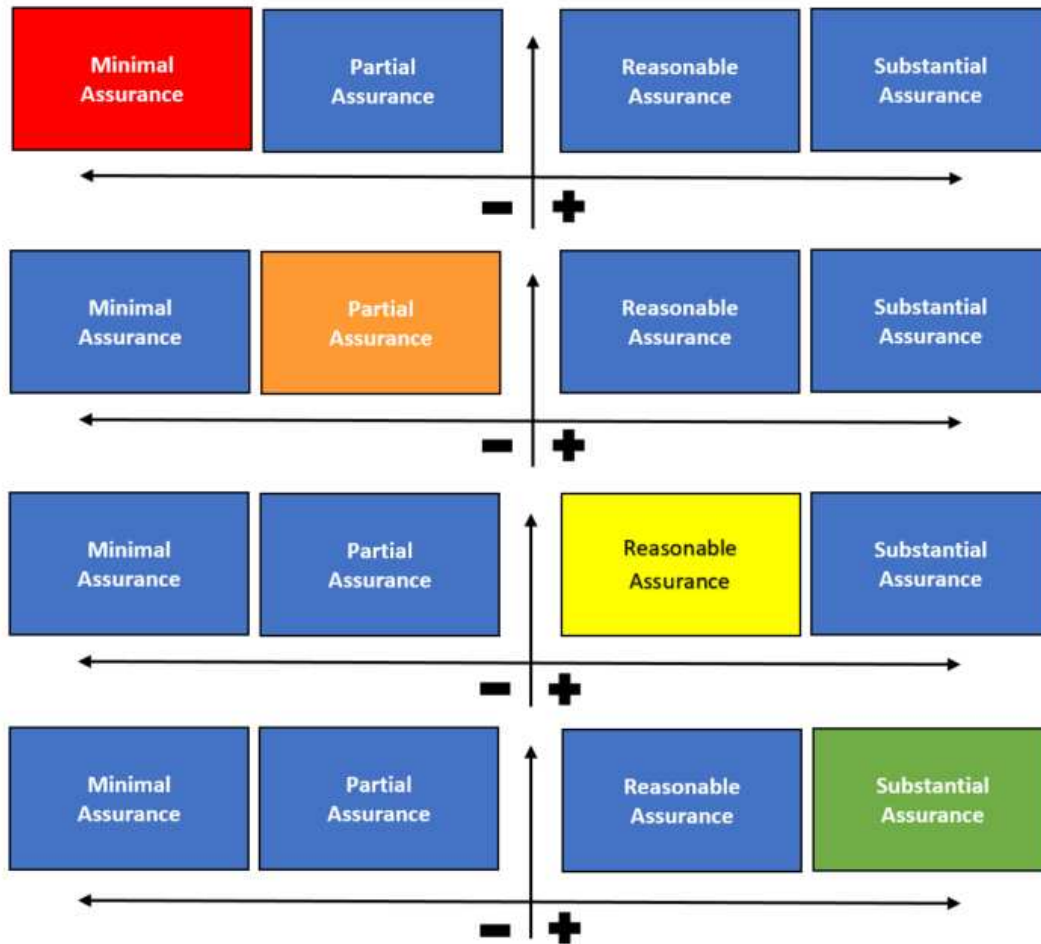
## Finance & Investment Committee Chairs Report

**Committee Chair:** Mike O'Donovan

**15 April 2026**

Agenda Item 3: Month 12 Finance Report	<b>Substantial Assurance</b>
Agenda Item 3: Financial Improvement Plan 2026/27	<b>Reasonable Assurance</b>
Agenda Item 3: Month 12 Cash Position	<b>Reasonable Assurance</b>

<p><b>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)</b></p> <ul style="list-style-type: none"> <li>N/A.</li> </ul>	<p><b>MAJOR ACTIONS AGREED (ADVISE)</b></p> <ul style="list-style-type: none"> <li>N/A</li> </ul>
<p><b>POSITIVE ASSURANCES TO PROVIDE (ASSURE)</b></p> <ul style="list-style-type: none"> <li>2025/26 financial plan delivered with receipt of Deficit Support Funding (DSF) of £3.28m.</li> <li>Significant progress in relation to identifying savings for 2026/27</li> <li>Positive closing cash position. Work in progress to confirm requirements for 2026/27.</li> </ul>	<p><b>DECISIONS MADE (APPROVE)</b></p> <ul style="list-style-type: none"> <li>N/A</li> </ul>



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There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

## Finance & Investment Committee Part I

Wednesday 15 April 2026

9.30 – 10.45

Boardroom, Level 4, Royal Berkshire Hospital

### Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Mrs. Frances Khatcherian	(Chief Finance Officer)
Dr. Janet Lippett	(Chief Medical Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Andrew Statham	(Chief Strategy Officer)

### In Attendance

Mr. Oke Eleazu	(Chair of the Trust)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)
Ms. Tracey Middleton	(Director of Estates and Facilities)
Mrs. Tara Whittington	(Head of Corporate Governance)

### 53/26 Declarations of Interest

There were no declarations of interest.

### 54/26 Minutes for Approval: 18 March 2026 & Matters Arising Schedule

The minutes of the meeting held on 18 March 2026 were approved as a correct record and signed by the Chair.

Minute 36/26: Month 11 Finance Report including Financial Improvement Plan 2025/26:

The Chief Finance Officer confirmed that the Trust would not be required to repay circa £30m over three years as the year-end plan had been achieved.

Minute 38/26: Draft Budget 2026/27: A close down letter from the Regional Director would be circulated via the NED brief email at the end of the week. **Action: S McManus**

Minute 39/26: Capital Programme Update 2026/27: The Chief Operating Officer confirmed that a business case for the expansion of the emergency department was being developed and would be submitted to NHS England following Board approval. **Action: D Hardy**

### 55/26 Month 12 Finance Report including Financial Improvement Plan 2025/26

The Chief Finance Officer highlighted that the Month 12 financial performance was a position was year to date deficit of £4.52m, £3.28m better than plan. This was due to additional Deficit Support Funding (DSF) received as the Trust had delivered its plan.

The Chief Finance Officer reported that the Trust was overspent on pay by circa £9m excluding pension. An exercise was ongoing to review Whole Time Equivalents (WTEs).

**Action: F Khatcherian**

The Trust was £312k overspent on capital although capital payments in April 2026 would reduce this position.

The Chief Finance Officer advised that there was a need to better understand activity data linked to income. Data quality presented an issue in relation to activity being correctly captured to both enable teams to review their budget positions as well as ensuring that income was correctly invoiced. The Chief Finance Officer advised that the prior year adjustment was still being reviewed with external auditors.

The Committee noted that a significant proportion of the savings for 2026/27 had already been identified. Work was ongoing to strengthen financial controls as well as accelerate transformation work. The Chief Operating Officer highlighted that as part of the Digital, Data & Technology (DDaT) programme a proposal in relation to Ambient Voice Technology (AVT) had been supported by the Executive Management Committee (EMC) and a business case was being developed.

The Chief Finance Officer reported it was anticipated that the savings programmes for 2026/27 would be finalised by the end of June 2026 and this would include a focus on a 3-year plan.

The Committee noted that work was ongoing to review drug expenditure in relation to contracts and funding from the Integrated Care Board (ICB). Data was being received to improve understanding of the drug overspend and to determine whether this represented a cost pressure.

The Chief Finance Officer reported that the cash position at Month 12 was over £25m. However, there was a need to finalise the savings programme to ascertain whether the Trust would require cash support for 2026/27.

It was agreed that a report would be submitted to the April private Board that would set out the financial improvement plan for 2026/27 and this would also include lessons learned.

**Action: F Khatcherian**

## **56/26 Key Messages for the Board**

Key messages for the Board included:

- Achieved year-end financial plan noting there were outstanding issues to be addressed
- The prior year adjustment was still being reviewed with external auditors

## **57/26 Date of Next Meeting**

It was agreed that the next meeting would take place on Wednesday 20 May 2026 at 9.30am.

**SIGNED:**

**DATE:**

## Quality Committee Chairs Report

**Committee Chair:** Helen Mackenzie

**22 April 2026**

Agenda Item 9: Patient Relations Update	<b>Minimal Assurance</b>
Agenda Item 11: Legal Services/ Claims Update	<b>Partial Assurance</b>

### MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

- Alert that one of the three Patient Safety Incident Investigations was a near miss never event involving wrong-site attempted surgery of the eye.
- Alert that there were three high risk inquests in Quarter 1 that would be reported in the weekly NED briefing when due.
- Alert that there was a backlog of 500–700 patients awaiting Oral and Maxillofacial (OMF) triage, a service provided by Oxford University Hospitals Trust.
- Alert that a new risk regarding the Maternity building had been added to the Corporate Risk Register.

### MAJOR ACTIONS AGREED (ADVISE)

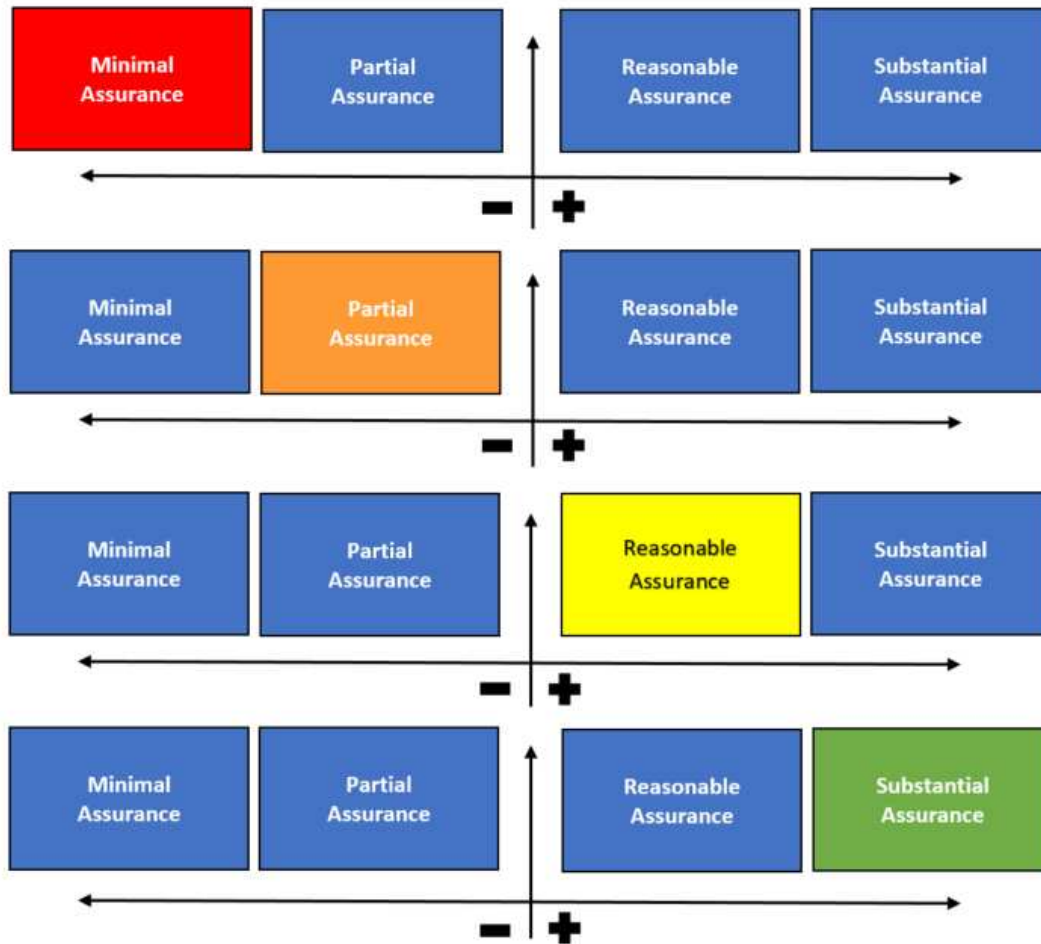
- Advise of the MOSS alert receipt and that actions accepted by the regional team.
- Advise the Board that the number in perinatal mortality rate would increase from 3.79 per 1000 births (2024) to 6 per 1000 births (2026) and that there was a global majority outlier status within these figures and a new driver metric has been introduced to ensure actions were monitored.
- Advise that there were 3 Patient Safety Incident Investigations, 7 Multidisciplinary Team reviews and 34 Rapid Reviews.
- Advise that the Trust was planning to continue to use escalation spaces rather than keep patients waiting in A&E. This means that where a patient has waited for over 45 minutes implementing in an escalation space a report would be made to the region.
- Advise that there was a continued low (52%) response rate to complaints within 25 days.
- Advise that an update was received on Health Inequalities and that two Public Health consultants by local councils had been recruited to support the development of priorities. w
- Advise that a report was received on Legal Services and Claims.

### POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- A comprehensive report on Learning from Deaths had been received and that processes were made clear.

### DECISIONS MADE (APPROVE)

- None



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## Notes

### Quality Committee Notes

Wednesday 22 April 2026

10.00 – 12.00

Boardroom, Level 4

#### Members

Mrs. Helen Mackenzie	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Dr. Minoo Irani	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)

#### In Attendance

Ms. Sarah Bailey	(interim Director of Midwifery) (up to minute 21/26)
Ms. Helen Challand	(Deputy Chief Nurse)
Ms. Sharon Herring	(Associate Chief Nurse, Patient Experience, Workforce & Education) (for minutes 26/26 and 27/26)
Mrs. Caroline Lynch	(Trust Secretary)
Mrs. Tara Whittington	(Head of Corporate Governance)

[The meeting was not quorate]

#### Apologies

Mrs. Katie Prichard-Thomas (Chief Nursing Officer)

#### 18/26 Declarations of Interest

There were no declarations of interest.

#### 19/26 Minutes for Approval: 2 February 2026 and Matters Arising Schedule

The minutes of the meeting held on 2 February 2026 were received and would be submitted to the next meeting for approval.

**Action: C Lynch**

All matters arising had been completed or included as items on the agenda.

#### 20/26 Maternity Quality Assurance Report including Perinatal Mortality (PNM)

The interim Director of Midwifery introduced the report and highlighted that there had been an overall increase in perinatal mortality in Quarter 3 2025/26. This was due to a very small but significant number of still births and babies who had died within 7 days of birth. A review had been undertaken to identify any themes and/or learning. As a result, this had informed the development of Urgent Care driver metrics for reducing perinatal deaths. The trust's own predicted forecasted perinatal mortality rate for 2025/26 was 6:1000 total births. The interim Director of Midwifery reported that the data from Mothers and Babies: Reducing the risk through Audits and Confidential Enquiries (MBRRACE) had identified an overall increase in perinatal mortality nationally. The Committee noted that MBRRACE data was reported with a lag of two years. For 2024 it was 2.91 per 1000 total births.

The Committee noted that within the Trust's increased perinatal mortality rate there was a higher percentage of cases from global majority mothers. This had been discussed with the

Chief Medical Officer and as part of Urgent Care Driver Metrics, a new metric would be agreed on 'Reducing Perinatal Mortality with a focus on global majority'.

The interim Director of Midwifery reported that the recent perinatal mortality review indicated a reduction in the perinatal mortality rate. The Committee noted that the independent investigation into Maternity and Neonatal Services in England interim report was published in February 2026 and although a formal action plan had not yet been developed, the Trust's actions aligned with the recommendations set out in the report.

The interim Director of Midwifery reported that the Trust had received a level 1 MOSS alert that had been responded to in February 2026. The report had been circulated to the Committee.

The interim Director of Midwifery reported that actions from the Maternity Outcomes Signal System (MOSS) would be added to a dashboard and this would enable a detailed review into specific groups or causes of deaths from May 2026.

The interim Director of Midwifery reported an issue in relation to theatre capacity. The anaesthetics team were working to increase predictability on theatre transfers for women in labour. As part of this work, capacity for elective caesareans would be reviewed.

#### **21/26 Quarter 4 Patient Safety Report**

The Deputy Chief Nurse reported that incident reporting in Quarter 4 2025/26 had increased. Evidence demonstrated that increased levels of incident reporting reflected an open and positive safety culture.

The Deputy Chief Nurse reported that the Trust's Emergency Department was part of the first phase of the national programme for Call 4 Concern/Martha's Rule in A&E. Feedback from the initial patient wellness questionnaire pilot showed that this was a valuable tool for patients who considered it was a safe environment to provide feedback.

The Committee noted that a number of Call for Concern/Martha's Rule calls had been received from outside the Trust and agreed that the next report would set out the number of external calls. **Action: H Challand**

The Committee noted that there had been 41 rapid reviews and 7 multi-disciplinary reviews during Quarter 3 2025/26.

The Deputy Chief Nurse reported that an update on the completed actions from the KPMG PSIRF internal audit would be included in the next report. **Action: H Challand**

#### **22/26 Learning from Deaths Report**

The Chief Medical Officer provided an overview of the Trust's mortality performance for January and February 2026. A small number of deaths in January and February 2026 had been subject to patient safety investigations and reviewed through the Mortality Surveillance Committee. In January, two deaths had been investigated, with one case receiving a final grade of 3 and the other a grade of 1; overall care had been assessed as poor in one case and good in the other. In February, three deaths had been investigated, with two cases assigned a final grade of 1 and one case a grade of 2; overall care had been assessed as adequate in two cases and good in one.

The Chief Medical Officer reported that a change in process had been implemented to ensure that any deaths reviewed through the patient safety processes received a mortality grading at Patient Safety Incident Response Group rather than awaiting a repeat discussion at Mortality Surveillance Group.

The Committee discussed the need to understand how many of these deaths related to patients with a learning disability and/or autism and the need for assurance on the quality of care received. It was agreed that this would be included in future reports.

**Action: J Lippett**

The Chief Medical Officer reported that Structured Judgement Reviews for 2025/26 indicated that the majority of deaths reviewed were assessed as receiving 'good' or 'very good' care.

### **23/26 Integrated Performance Report (IPR) Quality Watch Metrics**

The Committee noted that in February 2026 the Trust had breached its threshold of 39 cases of C.Diff. with 53 cases to date. Improvement actions were being monitored through the C.Diff. action group led by the care groups.

The Chief Medical Officer reported that mixed-sex breaches had occurred, predominantly within the Trauma and Orthopaedics department. These breaches were concentrated in January 2026, when winter illness had resulted in full capacity and the ability to maintain single-sex accommodation was limited. In February 2026 levels reduced however the teams were working to see the numbers reduce further.

The Committee noted that there were a significant number of complaints with only 67% resolved within the 25 day target in February 2026. The Trust would be implementing an Artificial Intelligence (AI) tool and it was considered this would assist in complaints being resolved within the target.

### **24/26 Quality Governance Committee Report**

The Committee noted that there was a backlog of 500–700 patients awaiting Oral and Maxillofacial (OMF) triage. The Committee discussed this service that was provided by Oxford University Hospitals (OUH). The Chief Operating Officer advised that this had been escalated via senior management. The Committee noted that this presented a potential risk due to the delay of care. The Committee agreed that the Board should be alerted to this issue.

### **25/26 Corridor Care**

The Chief Operating Officer highlighted that there was a national focus on corridor care. The Trust did not provide corridor care generally although the national guidance considered that use of temporary escalation areas was considered as corridor care.

The Trust would continue to use temporary escalation areas. However, the Trust would be required to report in instances where patients were waiting more than 45 minutes in these areas to the region. The Committee noted that this was a risk-assessed process.

The Committee agreed that this data was aligned to the Trust's Strategic Objectives 1 and 3 and watch metrics and would be included in the Integrated Performance Report (IPR) going forward.

**Action: D Hardy**

**26/26 Patient Relations Update**

The Associate Chief Nurse, Patient Experience, Workforce & Education, introduced the report and advised that complaints had increased during Quarter 3 2025/26 and contacts with the Patient Advice and Liaison Service (PALS) had declined. It had been identified that patients were using AI in order to prepare their complaints and it was considered that this was a key factor in the increase in complaints and the reduction in PALS engagement. It was agreed that the Deputy Chief Nurse would benchmark the Trust's complaints with those of other acute providers.

**Action: H Challand**

The Associate Chief Nurse, Patient Experience, Workforce & Education, reported that only 52% of complaints were responded to within the 25 day target in Quarter 3. The Committee considered that this resulted in poor experience for patients. The Committee recommended that the Executive team should consider whether this risk should be added to the Corporate Risk Register via the Integrated Risk Management Committee.

**Action: H Challand**

It was agreed that a further update should be provided at the September meeting.

**Action: H Challand**

**27/26 Health Inequalities**

The Committee noted that the sustainability of funding for several programmes was a key risk, many of which were annually funded. The Associate Chief Nurse, Patient Experience, Workforce & Education, reported that funding for some programmes was at risk of being discontinued.

The Committee noted that two Public Health consultants had been recruited to identify key priority areas and this would include the development of a Trust-wide inequalities database and delivery plan. A report on their findings would be submitted to the Committee at a future meeting.

**Action: J Lippett**

**28/26 Legal Services/Claims Update**

The Committee noted that the team had seen an increase in workload due to a higher numbers of claims and inquests along with complexity from additional concerns raised by families. The Committee also noted an increase in requests for disclosure of records that had resulted in a backlog.

The Deputy Chief Nurse reported that a gap had been identified in the consistent and timely feedback of claim outcomes and associated learning to speciality teams. This posed a risk that learning was not fully embedded at clinical governance levels. The legal services team was working with specialities to establish regular learning updates through their governance meetings as well as a quarterly claims report presented to Care Group governance forums to support action planning and learning from claims.

**29/26 Board Assurance Framework (BAF)**

The Trust Secretary introduced the BAF and advised that on-going reviews were scheduled and would include the addition of target dates.

**Action: C Lynch**

**30/26 Corporate Risk Register (CRR)**

The Deputy Chief Nurse introduced the CRR and advised that risks had been updated and reviewed by the Integrated Risk Management Committee. The Committee noted a number of risks had been closed.

A risk related to the Maternity building was being developed for review in response to the fire safety works and would be submitted to the next IRMC. **Action: H Challand**

### **31/26 Committee Annual Review of Effectiveness and Terms of Reference**

The Trust Secretary introduced the Annual Effectiveness Review and Terms of Reference as part of the annual review cycle.

The Committee agreed that a recommendation should be submitted to the Board to approve the Effectiveness Review and Terms of Reference. **Action: H Mackenzie**

### **32/26 Work Plan**

The Committee received the work plan.

### **33/26 Key Messages for the Board**

The Committee agreed the following key messages for the Board:

- Advise of the MOSS alert receipt and that actions accepted by the regional team. The Quality Committee will continue to monitor this.
- Advise the Board that the number in perinatal mortality rate would increase from 3.79 per 1000 births (2024) to 6 per 1000 births (2026) and that there was a global majority outlier status within these figures and a new driver metric has been introduced to ensure actions were monitored.
- Advise that there were 3 Patient Safety Incident Investigations, 7 Multidisciplinary Team reviews and 34 Rapid Reviews.
- Alert that one of the three Patient Safety Incident Investigations was a near miss never event involving wrong-site attempted surgery of the eye.
- Alert that there were three high risk inquests in Quarter 1 that would be reported in the weekly NED briefing when due.
- Assure that a comprehensive report on Learning from Deaths had been received and that processes were made clear.
- Alert that there was a backlog of 500–700 patients awaiting Oral and Maxillofacial (OMF) triage, a service provided by Oxford University Hospitals Trust.
- Advise that the Trust was planning to continue to use escalation spaces rather than retain patients in ED. This would mean that where a patient had waited for over 45 minutes implementing in an escalation space a report would be made to the region.
- Advise that there was a continued low (52%) response rate to complaints within 25 days.
- Advise that an update was received on Health Inequalities and that two Public Health consultants by local councils had been recruited to support the development of priorities. w
- Advise that a report was received on Legal Services and Claims.
- Alert that a new risk regarding the Maternity building had been added to the Corporate Risk Register.

### **34/26 Reflections of the Meeting**

The Chief Operating Officer led a discussion.

### **35/26 Date of Next Meeting**

It was agreed that the next meeting would be held on Monday 1 June 2026 at 10.00.

**SIGNED:**

**DATE:**

# Quality Committee Annual Review of Effectiveness 2025/26

Helen Mackenzie  
Chair, Quality Committee

Caroline Lynch  
Secretary, Quality Committee

## 1. Summary

1.1. The purpose of this report is to give an update on the work on the Quality Committee over the past year, and to provide assurance to the Board that the Committee has carried out its obligations in accordance with its terms of reference.

## 2. Governance

2.1. The role of the Committee is to give detailed consideration to all components of the quality of care provided by the Trust including clinical effectiveness, patient safety and patient experience.

2.2. The Committee receives an exception report from the Quality Governance Committee at each meeting that sets out the key issues, risks and themes identified by that Committee.

2.3. The Quality Committee is a sub-committee of the Board. The Chair is responsible for escalating matters that the Committee considers need to be drawn to the attention of the Board when presenting the minutes of the Committee to the next meeting of the Board.

2.4. Helen Mackenzie was appointed Chair of the Quality Committee in January 2019.

2.5. The Committee's terms of reference were approved by the Board in March 2025. The Committee also maintains an annual work plan.

## 3. Meetings and Membership

3.1. The Committee met formally on five occasions between April 2025 and February 2026.

- 19 May 2025
- 21 July 2025
- 1 September 2025
- 3 December 2025
- 2 February 2026

3.2. The attendance record of members of the Committee is as follows

<u>Member</u>	<u>Maximum Number of Meetings</u>	<u>Number Attended</u>
Helen Mackenzie	5	5
Minoo Irani	5	5
Prof. Parveen Yaqoob	5	4
Chief Nursing Officer	5	4
Chief Medical Officer	5	5
Chief Operating Officer	5	4
Chief Executive	3	3
Chair	3	2

3.3. The Trust Secretary or their nominee has attended all meetings. Other Non-Executive Directors have attended meetings to observe. Other Directors and staff have attended meetings during the course of the year to advise and to respond to questions from the Committee. These have included the Deputy Chief Nursing Officer, Director of Midwifery,

interim Director of Midwifery, Associate Medical Director for Patient Safety, Director of Operations Urgent Care.

#### 4. Assurance

4.1. Items that were reviewed at each meeting or regular intervals include:

- Patient Safety Report
- Maternity Quality Assurance Report including Maternity Incentive Scheme (MIS)
- Quality Governance Committee
- Perinatal Mortality Surveillance Report and Perinatal Mortality Quarterly reports
- Perinatal Quality Surveillance Quarterly reports
- Corporate Risk Register
- Board Assurance Framework
- Patient Relations Quarterly reports
- Legal Services Summary
- Implementation of the Patient Safety Incident Reporting Framework (PSIRF)

4.2. The following items were also reviewed throughout the year:

- Prevention of Future Deaths Report
- Increasing National Benchmarking Mortality Metrics
- Mortality Review Metrics July 2025
- Reading Joint Targeted Area Inspection (JTAI) March 2025 for Unborns and Children who are victims of Domestic Abuse
- Four-hour Access Standard
- Clinical Audit Programme Update
- Care Quality Commission (CQC) Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Inspection Update
- Fuller Report Phase 2
- Hip Fracture Time to Theatre
- Home Birth Assurance Report
- Complaints Detailed Review
- Detailed Review Datix Reporting
- Mortality Surveillance Committee Report – Learning from Deaths
- Summary of latest maternity and neonatal national updates from NHS England
- Summary of Patient-Led Assessment of Clinical Environment (PLACE)
- Winter Plan 2025/26
- Improving Together

4.3. The following annual reports were received during the year:

- Prevention of Future Deaths Report
- Maternity & Adult Inpatient Surveys
- Patient Relations Annual Report 2025/26
- Patient Experience Annual Report 2024/25
- Complaints and PALs Annual Report
- Infection Prevention & Control Annual Report 2024/25
- Safeguarding, Mental Health, Learning Disabilities & Autism Annual Report 2024/25
- Learning Disability Progress Report
- Autism (Neurodiversity) Progress Report

- National Inpatient Survey

4.4. The Quality Strategy year one position was also reviewed during the year.

4.5. The Children & Young People Strategy was approved in July 2025.

4.6. In addition to the regular assurance received from items on the work plan, the Committee has sought and received assurance on the following specific issue:

- 62 Day Cancer Standard
- Delivering the Referral to Treatment standard 2025-26
- Emergency Department Standards Performance

## **Quality Committee**

### **Terms of Reference**

#### **Constitution and Membership**

The Committee will be appointed by the Board to give detailed consideration to all components of the quality of care provided by the Trust including clinical effectiveness, patient safety and patient experience.

The Committee is primarily concerned with the delivery of safe, high quality patient care. This will be achieved through its engagement with the Quality Assurance & Learning Committee and other sub-committees to obtain and provide assurance to the Board that:-

- (a) appropriate structures, processes and controls are in place to assure quality in clinical care and the patient experience
- (b) the key risks to safety and quality of clinical services are recognised and are being addressed to ensure their resolution in a timely manner.

The Committee will review and scrutinise papers and recommend to the Board as necessary.

The Committee will be chaired by a Non-Executive Director. The membership will include at least two further Non-Executive Directors, Chief Medical Officer or Chief Nursing Officer and the Chief Operating Officer.

Members will be expected to attend four out of six meetings.

The quorum of the Committee will be five members, including at least two Non-Executive Directors and two Executive Directors.

#### **Attendance**

The Chief Medical Officer or the Chief Nursing Officer are expected to attend all meetings. The Chief Executive and the Chair will attend 3 meetings annually.

Other staff may be asked to attend, including the Care Group Directors, Care Group Directors of Nursing, Chief Pharmacist and Head of Patient Safety, Head of Risk Management, Head of Patient Experience, Head of Research and Innovation and Deputy Chief Nurse for specific items only.

The Trust Secretary (or their nominee) will act as secretary to the Committee.

#### **Frequency of Meetings**

The Committee will meet at least five times a year and such other times as may be required.

#### **Monitoring**

The work of the Committee will be kept under review by the Board.

The Committee will conduct an annual review of its effectiveness with its terms of reference and submit any findings and proposals for changes to the Board of Directors for consideration.

## **Duties**

The Committee will:-

- (a) monitor the Quality Account including related actions and their impact
- (b) receive regular reports from the Quality Governance Committee on the actions being taken to ensure effective clinical governance in the Trust
- (c) examine issues of concern escalated by the Quality Governance Committee or its sub-committees or referred by the Board in respect of clinical governance matters in the Trust, consider action plans to deal with them and monitor their effectiveness
- (d) develop an annual work programme setting out key areas for attention in the coming year including, as a minimum:-
  - regular updates on the implementation and effectiveness of clinical outcomes, quality improvement, patient safety and patient experience
  - regular updates on progress against the Quality Account objectives
  - the implementation of actions plans following relevant regulatory inspections
  - gaps in assurance as identified on the Board Assurance Framework.
- (e) review KPIs and other metrics through the quality account dashboard, including those in respect of learning from serious incidents and never events, to provide assurance to the Committee and the Board in respect of the effectiveness of the clinical governance in the Trust
- (f) identify areas of significant risk to clinical safety, patient outcomes and patient experience, set priorities and place actions using the Board Assurance Framework
- (g) review clinical risks included in the Corporate Risk Register in terms of the effectiveness and timeliness of mitigating actions taken and to report to the Board and to the Audit & Risk Committee
- (h) receive periodic assurance reports on the progression of the Improving Together programme.
- (i) ensure that actions for improvement identified in incident reports, reports from HM Coroner and other similar documents are addressed
- (j) identify areas for improvement in respect of learning from incidents and complaints, from the results of national and local patient surveys/PALS and ensure appropriate action is taken
- (k) oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the trust (e.g. Human Tissue Authority)
- (l) monitor the Trust's compliances with the national standards of quality and safety of the Care Quality Committee, and NHS England's licence conditions relevant to patient safety and quality

- (m) Review clinical audit plans and related improvement including recommendations from external bodies being incorporated by the Trust (e.g. National Confidential Enquiry into Patient Outcomes and Death or Care Quality Commission)
- (n) Review the implications of confidential enquiry reports for the Trust and to endorse, approve and monitor the internal action plans arising from them.
- (o) Receive regular reports related to maternity services including Healthcare Safety Investigation Branch (HSIB) investigations.

### **Reporting**

The minutes of meetings will be formally recorded and submitted to the Board after each meeting.

The Committee will review these terms of reference on an annual basis and report to the Board accordingly.

**Reviewed by the Committee:**

**Approved by the Board:**

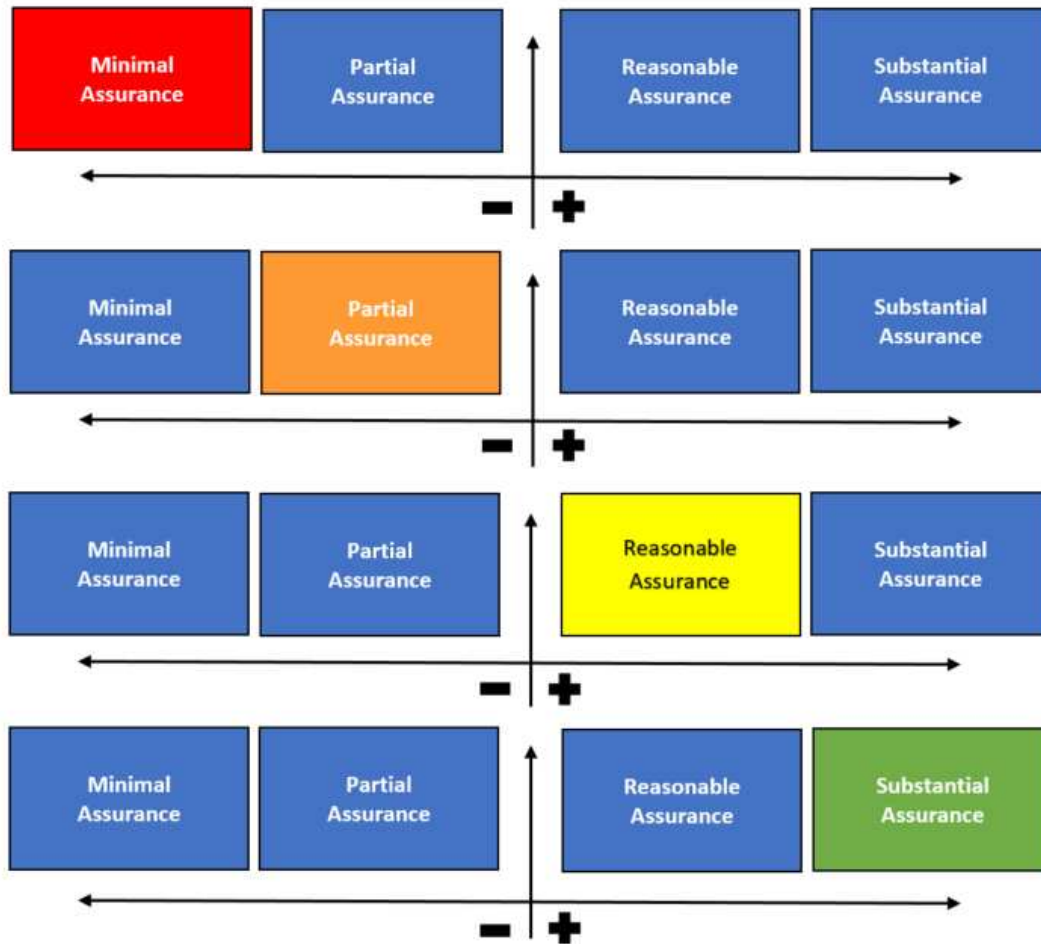
# People Committee Chairs Report

**Committee Chair:** Catherine McLaughlin

7 May 2026	
Agenda Item 3: Chief People Officer's Report	<b>Reasonable Assurance</b>
Agenda Item 5: Staff Survey Results	<b>Substantial Assurance</b>
Agenda Item 6: 2026 WRES Annual Report	<b>Substantial Assurance</b>
Agenda Item 7: 2026 WDES Annual Report	<b>Substantial Assurance</b>

7 May 2026	
Agenda Item 8: Occupational Health Annual Report	<b>Substantial Assurance</b>
Agenda Item 10: 10-Point Plan	<b>Substantial Assurance</b>
Agenda Item 11: Guardian of Safe Working Report	<b>Reasonable Assurance</b>

<p><b>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)</b></p> <ul style="list-style-type: none"> <li>Ongoing review of Band 5 nursing job descriptions due to be issued in May, supported by local briefings to ensure clarity on process and expectations and potential central funding available to support organisations</li> <li>Committee noted high % of colleagues experiencing unacceptable conduct (such as bullying, harassment and discrimination) from patients, visitors and members of the public</li> </ul>	<p><b>MAJOR ACTIONS AGREED (ADVISE)</b></p> <ul style="list-style-type: none"> <li>Guardian of Safe Working report highlighted exception reports from general surgery, ophthalmology (eye casualty) and renal with clear improvement plans in place</li> </ul>
<p><b>POSITIVE ASSURANCES TO PROVIDE (ASSURE)</b></p> <ul style="list-style-type: none"> <li>Positive assurance on the implementation of actions from the 2025 Staff Survey</li> <li>WRES and WDES reports received demonstrating strong benchmarked position relative to NHS average performance and in year trend in terms of the experience of global majority colleagues was largely one of improvement</li> <li>Resident Doctors 10 Point Plan</li> <li>Occupational Health Annual Report received noting an increase in demand for the service</li> </ul>	<p><b>DECISIONS MADE (APPROVE)</b></p> <ul style="list-style-type: none"> <li>Approved publication of WRES and WDES data on the Trust's website</li> </ul>



Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.

There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.

There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.

There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

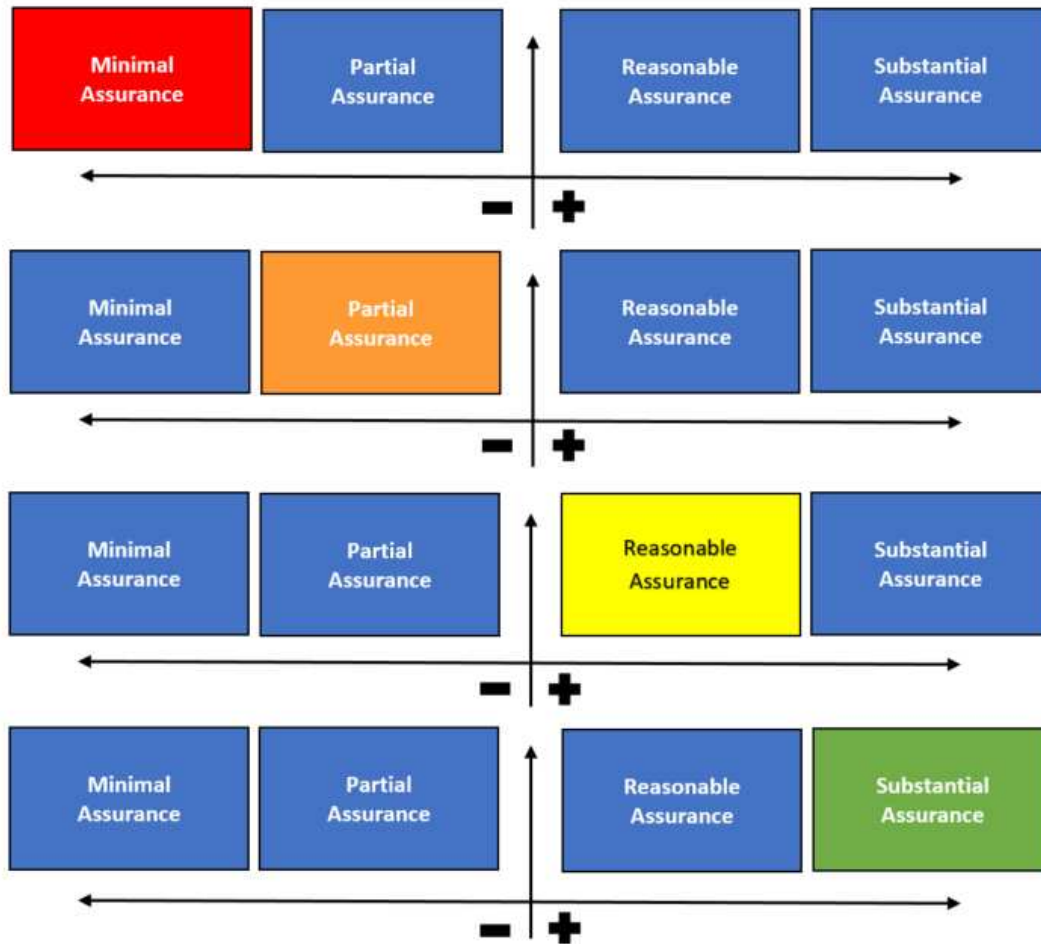
# Charity Committee Chairs Report



**Committee Chair:** Catherine Mclaughlin

**6 May 2026**

<p><b>MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)</b></p> <ul style="list-style-type: none"><li>• No matters of concern to report.</li></ul>	<p><b>MAJOR ACTIONS AGREED (ADVISE)</b></p> <ul style="list-style-type: none"><li>• A detailed options paper on the Charity’s strategic aims and future direction will be discussed at Private Board in May 2026.</li><li>• Advise that one new risk added to the Charity Risk Register regarding the use of MailChimp for supporter communications. This has been recommended by the Trust’s Information Governance and Cyber Security team and the Trust’s Data Protection Officer</li><li>• The expenditure target for 2026/27 of £2m was approved. Three funding rounds are being introduced during the year to help encourage teams. Teams can also access the general fund in the event of a shortfall (capped at 25% of the total project value).</li></ul>
<p><b>POSITIVE ASSURANCES TO PROVIDE (ASSURE)</b></p> <ul style="list-style-type: none"><li>• No matters on the agenda for assurance only.</li></ul>	<p><b>DECISIONS MADE (APPROVE)</b></p> <ul style="list-style-type: none"><li>• The budget for 2026/27 was approved.</li><li>• Recommendation to approve the Effectiveness Review and Terms of reference.</li></ul>



Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.

There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.

There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.

There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

## Charity Committee

Wednesday 6 May 2026

14.00 – 16.00

Boardroom, Level 4

### Present

Ms. Catherine McLaughlin	(Non-Executive Director) (Chair)
Mr. Jonathan Barker	(Public Governor, Reading)
Mr. Mike Clements	(Director of Finance)
Dr. Minoo Irani	(Non-Executive Director)
Mr. Umesh Jetha	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Dr. Sunila Lobo	(Public Governor, Reading)
Mr. John Stannard	(Patient Representative)
Ms. Jo Warrior	(Charity Director)

### In attendance

Mrs. Caroline Lynch	(Trust Secretary)
Mrs. Tara Whittington	(Head of Corporate Governance)

### Apologies

Ms. Adenike Omogbehin	(Staff Representative)
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### 10/26 Declarations of Interest

There were no declarations of interest.

### 11/26 Minutes for Approval: 4 March 2026 & Matters Arising Schedule

The minutes of the meeting held on 4 March 2026 were approved as correct and signed.

The Committee received the matters arising schedule. All matters had been completed or were included as items on the agenda.

Minute 06/26: Work Plan: Sunila Lobo advised that she would step down as a member of the Committee. Jonathan Barker would remain a member for the August meeting and Josh Wilson would be joining as the new governor representative. The Trust Secretary would seek expressions of interest from Governors following the August meeting. **Action: C Lynch**

### 12/26 Charity Director's Report

The Charity Director introduced the report summarising that the Charity had made good progress in relation to both fundraising and expenditure.

The next major donor event was scheduled for May 2026. This would be hosted by the Radiotherapy team to focus on how advances in technology had transformed cancer treatment

including a visit to see the LINAC equipment. Six major donors had confirmed to attend the event and the Charity team were aiming to increase this to 10.

The Charity Director reported that the Charity had exceeded its trusts and grants income target of £150k in Quarter 4 2025/26. The Charity Director highlighted this was as a result of the work of the team over the last two years, particularly, the part-time Charity Grants Manager.

The Charity Director reported that the Reading Half Marathon had raised more than £51k and this demonstrated the value of third party events.

The Charity Director encouraged members of the Committee to attend upcoming events such as the 30<sup>th</sup> Anniversary event in June 2026 and the Garden Party in July 2026. The Committee recommended that future reports should include the income target for each event.

**Action: J Warrior**

The Committee discussed the Charity's direction and fundraising ambition that had been previously discussed at the Charity workshop in March 2026. On average the Charity had raised circa £1.2m per year. Although work to better engage with major donors was underway, there was a need to increase focus on the establishment of this supporter group. This work was included as part of the future fundraising ambition of the Charity.

### **13/26 Charity Budget 2026/27**

The Director of Finance advised that the revised draft budget for 2026/27 included a more ambitious approach to charitable expenditure following discussion at the previous meeting. The income budget was in line with 2025/26 with a slight increase from £1.2m to just under £1.4m.

The Committee noted that the target spend for charitable expenditure for 2025/26 had been set at just over £2m. This was not realised within the year due to practical delivery factors rather than a lack of ambition. A target spend for 2026/27 was set at £2m. This was an increase from £1,690,000 in the draft budget discussed at the previous meeting. The Committee approved the Charity Budget for 2026/27.

### **14/26 Corporate Volunteering**

The Charity Director reported that whilst Corporate Volunteering produced positive outcomes the financial gain for the Charity did not justify the level of planning and supervision required for these events to take place. To date, the Charity team had supported these events. However, this was not sustainable.

The Charity Director presented two options for consideration. One option was a pilot partnership with an external corporate volunteering provider to focus on a single contained project area. A second option was a longer-term investment to recruit a role to co-ordinate corporate volunteering.

The first option required no salary or on-costs, met demand immediately, confined activity to a single site and reduced the operational burden on the Charity and Trust teams. However, it did not create capacity for other charity-funded projects, offered limited pilot flexibility, reduced direct ownership of corporate relationships and did not proactively develop new project opportunities.

The second option would provide a single, consistent point of coordination, enable flexible responses to Trust-wide priorities, strengthen relationships with internal teams and corporate partners, and enable strategic growth of corporate volunteering with benefits beyond a single site. However, it would require commitment to salary and on-costs, recruitment and line management, and a lead-in period before full capacity was realised.

The Charity Director recommended that the Charity should start with a six-month pilot partnership with the external corporate volunteering provider focused solely on the Oasis Staff Health & Wellbeing garden. This would provide a low-risk and cost-neutral way to manage demand whilst maintaining quality and reducing pressure on the Charity and Trust teams. The learning from the pilot would inform a decision as to whether to recruit a substantive role in the future.

It was agreed that the Charity Director would submit an updated report on the pilot at the next meeting. **Action: J Warrior**

### 15/26 Charity Funding Rounds

The Charity Director reported that as of April 2026, the Charity held £2.88m across 84 active, useable funds. It was proposed that the forecast charitable expenditure of £2m in 2026/27 could be supported via three funding rounds, providing the opportunity for match funding capped at 25%, to run alongside the existing grant application process. This would provide Fund Advisors time to develop good-quality proposals and work within project approval processes as required. The proposed timetable would involve bid deadlines in June, September and October and would enable five months for procurement, project completion and invoicing after the final deadline.

The Charity Director highlighted the need to set a time limit of six to nine months for projects to commence once funding had been approved in order to ensure it was spent.

The Committee approved the proposal of the Charity funding rounds.

### 16/26 Finance Report

The Director of Finance provided an update of the financial performance of the Charity for 2025/26. As at Month 12, the Charity's fund balances had increased by £14k from the start of the finance year due to large legacies received or accrued. The Committee noted that expenditure was below plan and the introduction of funding rounds was being implemented to support achievement of the £2m expenditure target for 2026/27.

The Director of Finance reported that reserves had been reduced. This included the Cardiology department who reduced their charitable funds from £184k to £74k.

The Charity Director advised that the Charity did not employ a member of staff to manage the stewardship of legacies. One member of the team who worked 15 hours a week currently, oversaw this in addition to other duties although they were due to leave at the end of June 2026. The Charity planned to recruit into this role. However, the scope of the job description would need to be reviewed. The Committee considered that if it should be considered that resource was required to develop legacy donors the Charity Director would discuss with the Chief Medical Officer. **Action: J Warrior**

### 17/26 Charity Risk Register

The Committee noted a new risk regarding future use of MailChimp for supporter communications. The risk had been raised as data would be processed and stored by a US-based third party. The Trust Secretary advised that the Data Processing Impact Assessment (DPIA) had been completed for MailChimp and whilst the information governance score was low it constituted an international data transfer. The Charity had therefore been advised to add this to the Charity risk register. It was recommended that the risk score should be discussed with the Head of Risk Management. **Action: J Warrior**

The Committee noted two further risks on the risk register remain unchanged. These risks related to Charity specialised staff roles potentially risking business continuity resilience and to data protection being potentially compromised in the event of Cyber Security breach. The Committee agreed these risks should be reviewed further as they had been on the risk register for some time. **Action: J Warrior**

### 18/26 Committee Terms of Reference

The Trust Secretary introduced the terms of reference as part of the annual review cycle.

The Committee agreed that the terms of reference should be updated to state that, at least one of the Governor representatives should be a Public Governor. **Action: C Lynch**

The Committee agreed that a recommendation should be made to the Board to approve the revised terms of reference. **Action: C McLaughlin**

### 19/26 Work Plan

The Trust Secretary introduced the work plan. It was agreed that the work plan would be reviewed with the Charity Director. **Action: C Lynch**

### 20/26 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Advise that a discussion was held on the Charity's direction and funding ambition and that a report would be submitted to the Board in May.
- Advise that a staged approach for the fundraising ambition would be the preferred option.
- Advise that the budget for 2026/27 had been approved.
- Advise that there had been an increase to £2m for the expenditure target with support of the three funding rounds.
- Advise that the revised terms of reference be approved.
- Advise that there was one new risk on the Charity risk register regarding the use of MailChimp.
- Advise that restricted funds had been reduced due to work over the last few years

### 21/26 Reflections of the Meeting:

The Director of Finance led a discussion.

### 22/26 Date of the Next Meeting:

It was agreed that the next meeting would be held on Wednesday 5 August 2026 at 14.00.

**SIGNED:**

**DATE:**

## **Charity Committee**

### **Terms of Reference**

#### **Constitution and Membership**

The Royal Berkshire Hospital Trust Charitable Fund (Charity Registration Number 1052720) is governed by the Trust Deed which was approved by the Trustees. Under the terms of the deed the Charitable Fund is administered and managed by the Trustees, the members of the Royal Berkshire NHS Foundation Trust as a body corporate.

The Trustees derive their authority to act from the Trust deed of the NHS Trust Charitable Fund, approved by the Trustees.

The Corporate trustee is the Board of Directors and they delegate operational accountability to the Charity Director, monitored by the Charity Committee.

The Committee will be chaired by a Non-Executive Director of the Trust. Additional membership will include another Non-Executive, the Chief Medical Officer, Trust Secretary, Director of Finance, two public Governors nominated by the Council of Governors, a staff representative, a patient representative and the Charity Director.

#### **Attendance**

The quorum will be four members including the committee Chair, Charity Director and two other members.

External advisers may attend as necessary at the request of members. The Chief Executive and the Chair will attend two meetings annually.

The Trust Secretary (or their nominee) will act as a member and secretary to the Committee.

#### **Frequency of meetings**

The Committee will meet at least four times a year.

#### **Monitoring**

The work of the Charity Committee will be kept under review by the Board.

The Committee will conduct an annual review of its effectiveness with its terms of reference and submit any findings and proposals for changes to the Board for consideration.

The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution of the Charity, the Standing Orders and the Standing Financial Instructions of the Trust.

The minutes of Committee meetings will be formally recorded and submitted to the Board of Directors.

#### **Committee Duties**

The members of the committee are responsible for the oversight and enquiry of the management of the Charitable Funds, through the Charity Director. They are required to:

- a) satisfy themselves that best practice is followed in terms of guidance from the Charity Commission, National Audit Office, Department of Health and other relevant organisations;
- b) ensure that the appropriate policies and procedures are in place to support the Charitable Funds Strategy and to advise Fund Managers on income and expenditure and that this is reviewed at regular intervals;
- c) develop the Foundation Trust's Charitable Funds Strategy and on an annual basis and recommend changes to the Charity Board where appropriate;
- d) obtain assurance that a separate register of interests is compiled for both Trustees and Fund Managers, and that this is reviewed and updated on a regular basis;
- e) approve fundraising policies that comply with statutory requirements in conjunction with the Board.
- f) on an annual basis, review and recommend income and expenditure plans, compiled from Fund Managers' detailed plans, ensuring that they complement the strategy.
- g) seek assurance that an effective mechanism exists whereby equipment needs are identified and satisfied, within resource constraints, through an equitable bidding process underpinned by business plans.
- h) receive assurance that all research monies paid into charitable funds meet the criteria for charitable status as specified by the Charity Commission;
- i) review the number of funds on an annual basis and undertake a programme of rationalisation, where appropriate;
- j) keep the equivalent of one year's running costs in reserves

**Reviewed by the Committee:**

**Approved by the Board:**

<b>Title:</b>	<b>Chief Executive's Report</b>
<b>Agenda item no:</b>	6
<b>Meeting:</b>	Board of Directors
<b>Date:</b>	27 May 2026
<b>Presented by:</b>	James Blythe, Chief Executive
<b>Prepared by:</b>	Caroline Lynch, Trust Secretary

<b>Purpose of the Report</b>	<ul style="list-style-type: none"> <li>To update the Board with an overview of key issues since the previous Board meeting.</li> <li>To update the Board with an overview of key national and local strategic environmental and planning developments</li> <li>This includes items that may impact on policy, quality and financial risks to the Trust.</li> </ul>
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<b>Report History</b>	None
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<b>What action is required?</b>	
Assurance	
Information	For information and discussion: The Board is asked to note the report
Discussion/input	
Decision/approval	

<b>Resource Impact:</b>	None
<b>Relationship to Risk in BAF:</b>	
<b>Corporate Risk Register (CRR) Reference /score</b>	
<b>Title of CRR</b>	

<b>Strategic objectives</b> This report impacts on				
Delivering the highest quality care for all				✓
Supporting our people to thrive				✓
Partnering for impact				✓
Driving improvement and enabling innovation				✓
Building a sustainable future together				✓
<b>Well Led Framework applicability:</b>			Not applicable <input type="checkbox"/>	
1. Leadership <input type="checkbox"/>	2. Vision & Strategy <input type="checkbox"/>	3. Culture <input type="checkbox"/>	4. Governance	<input type="checkbox"/>
5. Risks, Issues & Performance <input type="checkbox"/>	6. Information Management <input type="checkbox"/>	7. Engagement <input type="checkbox"/>	8. Learning & Innovation	✓
<b>Publication</b>				
Published on website		Confidentiality (Fol)	Private	Public
				✓

## Secretary of State for Health & Social Care

Following the resignation of Wes Streeting, James Murray was appointed Secretary of State for Health and Social Care by on 14 May 2026. James was previously Chief Secretary to the Treasury from 1 September 2025 to 14 May 2026.

### **Strategic Objective 1: Delivering the highest quality care for all**

#### Care Quality Commission (CQC) Urgent & Emergency Care (UEC)

- 1.1 We continue to engage closely in our partnership with the CQC. CQC colleagues will be visiting us as part of routine engagement in June 2026 and will be spending some time meeting teams working on our UEC pathways. We are working with them ahead of this to ensure we provide ongoing assurance about these services.

#### Performance Trajectories

- 1.2 Operational performance during April 2026 has met or been close to planned trajectories. For UEC, performance against the 4-hour standard has been slightly below plan. There was significant growth – 17% - in all types of attendance compared with April 2025 and so we are working closely with system partners to understand the reasons for this extremely large growth and to understand the actions that will be taken to rein this back.
- 1.3 Headline cancer performance against plan was slightly below plan at this point but we expect this to improve as validation is completed over the month. Referral To Treatment (RTT) performance is above plan at this stage.

#### **Meningococcal Disease cluster in the local area**

- 1.4 The Trust has been involved in the multiagency response to a small cluster of cases of Meningococcal Disease; providing care for four linked cases. Whilst three of the patients have made a full recovery, one requiring a short stay on Paediatric Intensive Care Unit (PICU) at Oxford University Hospital (OUH), the third patient sadly died. The age range of the patients was 9 -18 and they were linked through a class cohort at Henley College. Although some of the patients attended other schools they were all linked back to this initial cohort. The patients were confirmed as having Meningococcal B (Men B); the strain differing to the recent outbreak in Kent.
- 1.5 Multiple teams, including Emergency Department (ED), Intensive Care Unit (ICU), Anaesthetics, Infection Prevention & Control (IPC) and Microbiology have been involved in the response, and we would like to take this opportunity to thank them for their hard work and professionalism. UK Health Security Agency (UKHSA) also praised our staff for their prompt recognition and notification of the cases and also for assisting in providing antibiotic prophylaxis to close family contacts of the cases. ED experienced a steady stream of concerned patients over the following few days; some requiring prophylaxis, many just needing reassurance. Plans were put in place for a small close knit cohort of students at the college to receive antibiotics and subsequently vaccination. Some of our staff involved in the resuscitation attempt have also received antibiotics as a precaution.
- 1.6 Many of our staff have asked whether we could provide vaccination in the future. Men B vaccination is not currently part of the national vaccination regime and therefore could only be provided privately. As we already provide private holiday vaccinations through the vaccine centre we are investigating whether this could be an additional service which we could provide.

## **Strategic Objective 2: Supporting our people to thrive**

### Chief Executive transition

- 2.1 I would like to put on record my thanks to Steve McManus for a smooth and effective handover. Steve's values-based, compassionate and skilful leadership of the CEO team and whole organisation has put the Trust on a strong footing and I look forward to working with the Board to build on this over the coming months and years.

### 2026 CARE awards

- 2.2 Last week the Trust held its annual CARE Awards celebrating the amazing achievements of staff. From the 578 nominations showcasing some excellent examples of pioneering work, there were 52 shortlisted for the 13 categories including Newcomer of the Year; Outstanding Contribution to Equality and Diversity; Volunteer of the Year Outstanding Compassion in Care and Lifetime Achievement. There was a final award - People's Choice - which was presented to outgoing CEO Steve McManus. Thanks to the Trust's Communications and Engagement team for organising the event which was sponsored by the Royal Berks Charity.

### Equality, Diversity and Inclusion

- 2.3 In May 2026, the People Committee received update reports relating to two National NHS Workforce Equality Standards – firstly the Workforce Race Equality Standard (WRES) and secondly the Workforce Disability Equality Standard (WDES).
- 2.4 Trust performance across both standards evidences a strong benchmarked position relative to NHS average performance across many constituent metrics. The in-year trend in terms of the experience of global majority colleagues was largely one of improvement. Whilst the Trust retained its position as a Top 10 performing Trust in 5 of the 9 Staff Survey derived measures in the Workforce Disability Equality Standard, the in-year trend in terms of the experience of disabled colleagues was largely one of in year deterioration.
- 2.5 Along with overarching analysis of our full Staff Survey performance through an inclusion lens, key areas of ongoing focus for the Trust in the year ahead include (1) The high % of colleagues experiencing unacceptable conduct (such as bullying, harassment and discrimination) from patients, visitors and members of the public and (2) A need to remain focussed on development and progression pipelines to provide opportunities to grow and progress in the organisation. Relevant Action plans have been developed.

### Non-Executive Director (NED) recruitment

- 2.6 Following interviews held on 19 March 2026, Suzanne Byrne has been appointed by the Council of Governors as a Non-Executive Director. Suzanne is currently the Group Customer Director at Taylor Wimpey, a position she has held since May 2017.

### Associate NED with University of Reading

- 2.7 To further strengthen our relationship with the University of Reading we are currently in the process of the interview process to appoint an Associate Non-Executive Director to the Board.

### **Strategic Objective 3: Partnering for impact**

- 3.1 The Thames Valley system has submitted its 'Working together to improve outcomes, reduce inequalities and drive change' document to NHS England in May 2026. This will feed into the development of the Thames Valley Integrated Needs Assessment and Population Health & Commissioning Strategy.
- 3.2 Central to this approach is the use of population segmentation (via Johns Hopkins Patient Need Groups), that highlights that a small proportion of high-need patients drive a disproportionate share of demand and cost. With an ageing population and rising complexity of need, the system faces significant projected growth in demand and a potential 46% increase in costs by 2029/30 if no action is taken, alongside widening health inequalities in more deprived communities.
- 3.3 In response, the document sets out three core objectives: improving population outcomes through prevention and proactive care, driving equity by targeting underserved groups, and reducing unwarranted variation in quality and cost. Delivery is centred on a "left shift" in care, moving activity upstream through optimised pathways, slowing progression of disease, and addressing unmet need. The primary delivery model is neighbourhood health, with Integrated Neighbourhood Teams coordinating care across primary, community and secondary services to improve access, prevent hospital admissions, and manage high-risk populations more effectively. Programmes will focus on the 5% of patients who, without transformation, are expected to account for 30% of healthcare resource use over the next five years.
- 3.4 To enable this transformation, the system is evolving provider models and financial approaches toward outcome-based commissioning, supported by the Thames Valley Innovation Fund, expanded use of Artificial Intelligence (AI) and data, and stronger partnerships across health, local government and research. A robust measurement and evaluation framework will underpin the strategy, linking short-term delivery metrics to long-term population outcomes and enabling decisions to scale, adapt or stop interventions. Overall, the programme represents a shift to a more integrated, value-driven system focused on measurable impact, financial sustainability, and improved health outcomes across the population.

### **Strategic Objective 4 – Driving improvement and enabling innovation**

#### Same Day Emergency Care (SDEC)

- 4.1 This month we opened our new Same Day Emergency Care space adjacent to our Emergency Department. With £3.5m capital, this has transformed the former urology procedures space (now located in the new Frederick Potts building) into a purpose built SDEC space with 6 patient bays, recliner chairs, and procedure rooms. I would like to thank all of the teams who made this work possible.

#### Value Stream Analysis (VSA) Event 6 - 10 July 2026

- 4.2 Following the success of recent Rapid Process Improvement Workshops (RPIWs) across RBFT, we are now expanding our improvement approach through the introduction of Value Stream Analysis (VSA).
- 4.3 Recent RPIWs have delivered meaningful improvements for both patients and staff across the Trust. This includes work within Trauma & Theatres to improve theatre utilisation and communication, Paediatric SDEC initiatives to reduce time spent in ED, and improvements within Maternity Delivery Suite to strengthen post-operative safety and efficiency.

- 4.4 While an RPIW focuses on improving a specific part of a patient pathway during a rapid improvement week, a VSA takes a wider view — mapping the entire patient journey from start to finish to identify opportunities for larger-scale improvement and stronger collaboration across teams
- 4.5 Our first VSA will focus on the Emergency Surgical Pathway, with the aim of streamlining the pathway for patients who arrive via ED and require surgical intervention. This is aligned to our 'Care Where I Am' Strategic Programme and will contribute to reducing admissions, reducing length of stay and improving the experience for these patients.
- 4.6 The event will take place during the week commencing 6 July 2026 and will bring together multidisciplinary teams from across the Trust to map the pathway, identify challenges and agree future improvement priorities. The output of the VSA will shape a longer-term programme of improvement work, which may include future RPIWs, improvement projects and wider transformation activity aligned to the Trust's Strategy.

#### Digital Strategy (2026 – 2030)

- 4.7 The Board received an update in April 2026 on the Digital Strategy (2026–2030) and supporting Delivery Plan, outlining progress in positioning digital as a core enabler of the Trust's wider transformation. Discussion focused on delivery implications, including the need for shared organisational ownership and alignment with service transformation priorities.
- 4.8 Feedback from the Board highlighted the importance of a clear and sustainable financial approach, with future delivery dependent on prioritisation and alignment to the Trust's financial plan. The Digital Strategy will be submitted to the Board once detailed delivery plans are finalised, to confirm affordability, phasing and alignment with priorities

#### West Berks Community Hospital (WBCH) MRI Project

- 4.9 Last week we reached an important milestone on our new MRI building at West Berkshire Community Hospital, with the arrival of the building units on to site. The new state of the art facility will be home to two new MRI scanners and will be capable of delivering 17,500 MRI scans annually, meeting the growing demand for advanced diagnostic imaging across Berkshire West.
- 4.10 This facility will be the latest addition to the development of radiology facilities at West Berkshire Community Hospital. In 2021 the hospital became part of the government's Community Diagnostic (CDC) Programme and has seen substantial investment and improvements into imaging services.

#### Improving Together

- 4.11 Over the last 12 months the Improving Together team have been working to capitalise on our experience in driving continuous improvement. Through our "live lab" brand we are now supporting three NHS organisations to develop their approach, providing the Trust with a new income stream and valuable learning from across the country.

## **Strategic Objective 5: Building a sustainable future together**

### Financial Position – Month 1

- 5.1 I am pleased to report that the Trust has made a positive start to 2026/27. In Month 1 (April 2026), the Trust delivered a deficit of £1.11m, in line with our planned deficit of £1.12m. This represents on-plan performance and reflects the discipline the finance team and care groups have brought to the start of the year.
- 5.2 The Trust also delivered £2.13m of efficiency savings in the month, in line with plan. The Chair of Financial and Investment committee and the IPR will update the Board on the detail of financial performance, including income, pay, non-pay and cash, through the Month 01 Finance Performance Report at this meeting.
- 5.3 Whilst the headline position is encouraging, I want to be transparent with the Board that Month 1 is a starting point, not a settled position. Our full-year financial plan requires a step-change in efficiency delivery as the year progresses, and the Financial Improvement Programme that is now in part active and due to go live shortly across all 13 workstreams — is the primary vehicle through which we will achieve that. The programme's first formal Gate review is planned for early summer and will provide a more complete picture of our trajectory.
- 5.4 The Trust enters 2026/27 with a clear understanding of the financial challenge ahead. The structural pressures that characterised 2025/26; workforce costs, drugs expenditure, and income recognition have not been resolved by the year end. They form the basis of the improvement work now underway. The Board will receive monthly updates through the Finance & Investment Committee and this report.

### Land Search

- 5.5 The Trust is progressing plans for its new hospital under the New Hospital Programme (NHP) in Wave 3. Following a comprehensive site search, the Trust have received the final report from Mott MacDonald. The Trust is now seeking to secure option agreements on up to three sites, whilst undertaking detailed feasibility and due diligence, particularly on the preferred site, over the next six months. A briefing paper was submitted to NHP requesting enabling fees last month and there is an upcoming meeting with senior team at NHP next week.

<b>Title:</b>	<b>Integrated Performance Report (IPR)</b>
<b>Agenda item no:</b>	7
<b>Meeting:</b>	Board of Directors
<b>Date:</b>	27 May 2026
<b>Presented by:</b>	Katie Prichard-Thomas, Chief Nursing Officer
<b>Prepared by:</b>	Executive Team

<b>Purpose of the Report</b>	The purpose of this report is to provide the Board with an analysis of quality performance to the end of April 2026
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<b>Report History</b>	Executive Management Committee 26 May 2026
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<b>What action is required?</b>	
Assurance	
Information	The Board is asked to note the report
Discussion/input	
Decision/approval	

<b>Resource Impact:</b>	None
<b>Relationship to Risk in BAF:</b>	n/a
<b>Corporate Risk Register (CRR) Reference /score</b>	
<b>Title of CRR</b>	

<b>Strategic objectives</b> This report impacts on (tick all that apply)::				
Delivering the highest quality care for all				✓
Supporting our people to thrive				✓
Partnering for impact				✓
Driving improvement and enabling innovation				✓
Building a sustainable future together				
<b>Well Led Framework applicability:</b>			Not applicable <input type="checkbox"/>	
1. Leadership <input type="checkbox"/>	2. Vision & Strategy <input type="checkbox"/>	3. Culture <input type="checkbox"/>	4. Governance <input type="checkbox"/>	
5. Risks, Issues & Performance <input type="checkbox"/>	6. Information Management <input type="checkbox"/>	7. Engagement <input type="checkbox"/>	8. Learning & Innovation <input type="checkbox"/>	
<b>Publication</b>				
Published on website		Confidentiality (FoI)	Private	Public <input checked="" type="checkbox"/>

# Integrated Performance Report

April 2026

Improving together to deliver  
outstanding care for our community



# Guide to statistical process control (SPC)

## Introduction to SPC:

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action. The Improving Together methodology incorporates the use of SPC Charts alongside the use of Business Rules to provide aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change.

A SPC chart plots data over time and allows us to detect if:

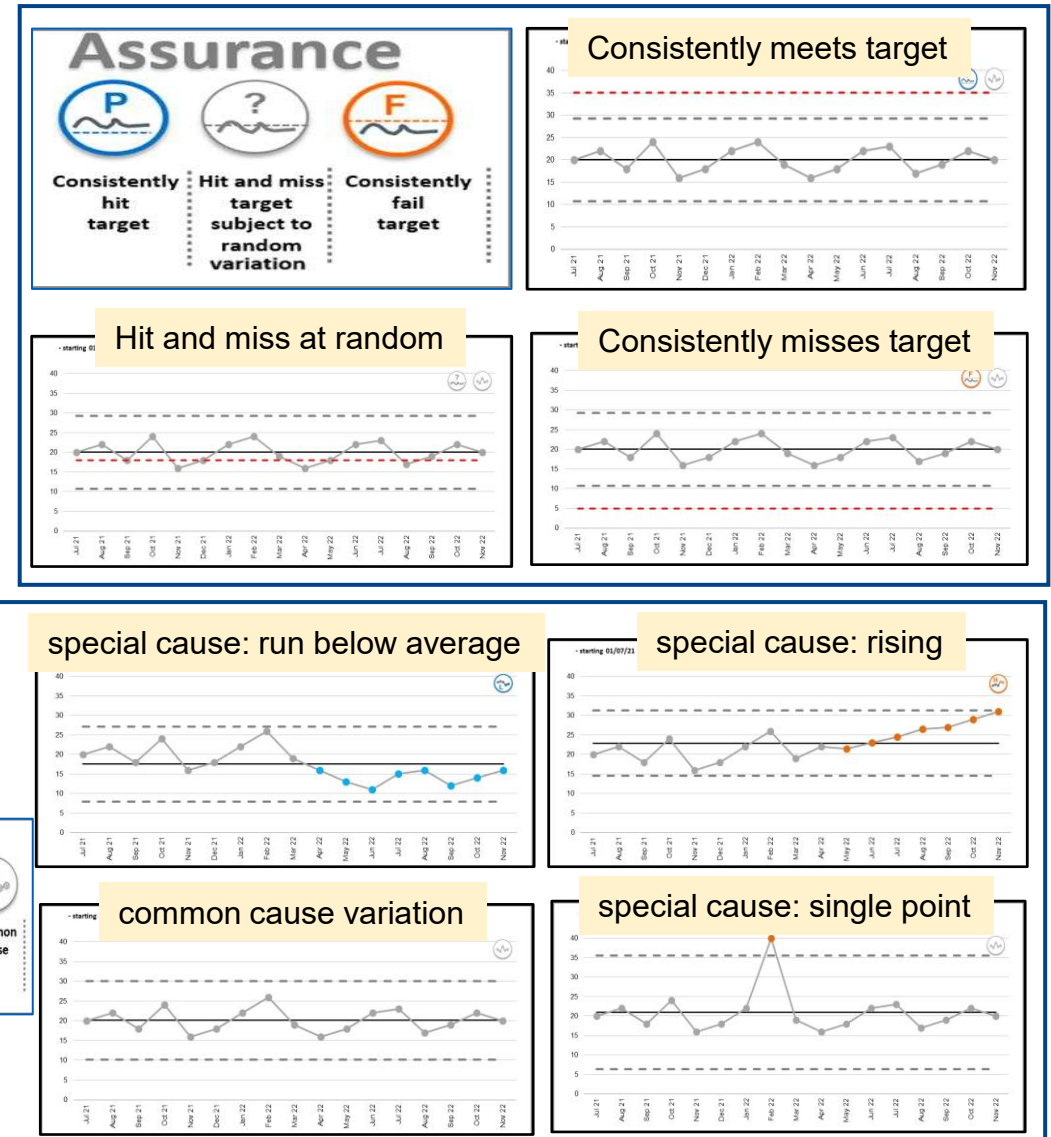
- The variation is routine, expected and stable within a range. We call this 'common cause' variation, or
- The variation is irregular, unexpected and unstable. We call this 'special cause' variation and indicates an irregularity or that something significant has changed in the process

Each chart shows a VARIATION icon to identify either common cause or special cause variation. If special cause variation is detected the icon can also indicate if it is improving (blue) or worsening (orange).

Where we have set a target, the chart also provides an ASSURANCE icon indicating:

- If we have consistently met that target (blue icon),
- If we hit and miss randomly over time (grey icon), or
- If we consistently fail the target (orange icon)

For each of our strategic metrics and breakthrough priorities we will provide a SPC chart and detailed performance report. We apply the same Variation and Assurance rules to watch metrics but display just the icon(s) in a table highlighting those that need further discussion or investigation.



# April 2026 performance summary

The data in this report relates to the period up to 30<sup>th</sup> April 2026. It is the first month of the refreshed strategic metrics for 2026/2027. The key messages from the report are:

- ED Performance:** April remained under sustained operational pressure. Overall, 76.49% of patients were seen within four hours, with Type 1 ED performance at 66.11%, representing a 0.8% improvement on the previous month. Demand increased by 17% compared to April 2025, while ambulance conveyance activity remained broadly in line with seasonal trends. Performance continues to be impacted by exit block and downstream bed capacity pressures. Work focused on improving patient flow and early discharge processes.
- Cancer performance:** 28-day faster diagnosis standard remains compliant with the Trust's planned trajectory for 2025-26. 62-day standard met the Trust's planned trajectory as well as the national ambition in March and is forecast to do so in April. Improvement actions continue, with the most challenged pathways reviewed weekly Cancer Action Group meetings.
- Financial performance:** April 2026 position the income and expenditure deficit of £(1.11)m is in line with agreed plan. We delivered £2.13m of the £43.69m efficiency savings plan; indicating that we are on track to deliver full-year breakeven plan for the financial year 2026/27.
- Cash:** There is evidence of strong cash management position at the end of April 2026. Closing cash balance is £30.85m. We continue to monitor and manage the cash balances to ensure liquidity remains through the financial year 2026/27.
- This month we have seen 16 of the 110 **watch metrics** measure outside of statistical control.
- Slide for SO4 – Driving Improvement and Innovation has been omitted from this report, as the metrics it covers are still in development. The slide will be added to the report starting next month and will appear in all future editions.

		Assurance			
					No Target
Variance				Emergency Department (ED) performance against 4hr target <a href="#">Page 10</a>	% of eligible patients using portal or NHS app within month <a href="#">Page 11</a> Productivity % Growth <a href="#">Page 13</a>
		Cash Performance <a href="#">Page 12</a>	Was listened to (FFT) <a href="#">Page 5</a> 62 day cancer standard (%) <a href="#">Page 8</a> 18wks RTT (%) <a href="#">Page 9</a> Ave LOS for non-elective patients (inc zero LOS) <a href="#">Page 15</a> Total Volume of first OP activity <a href="#">Page 16</a>		Patient Safety incidents/1000 bed days <a href="#">Page 6</a> Avoidable absence in days lost per month <a href="#">Page 7</a> Total WTE worked <a href="#">Page 17</a>

# Strategic Metrics

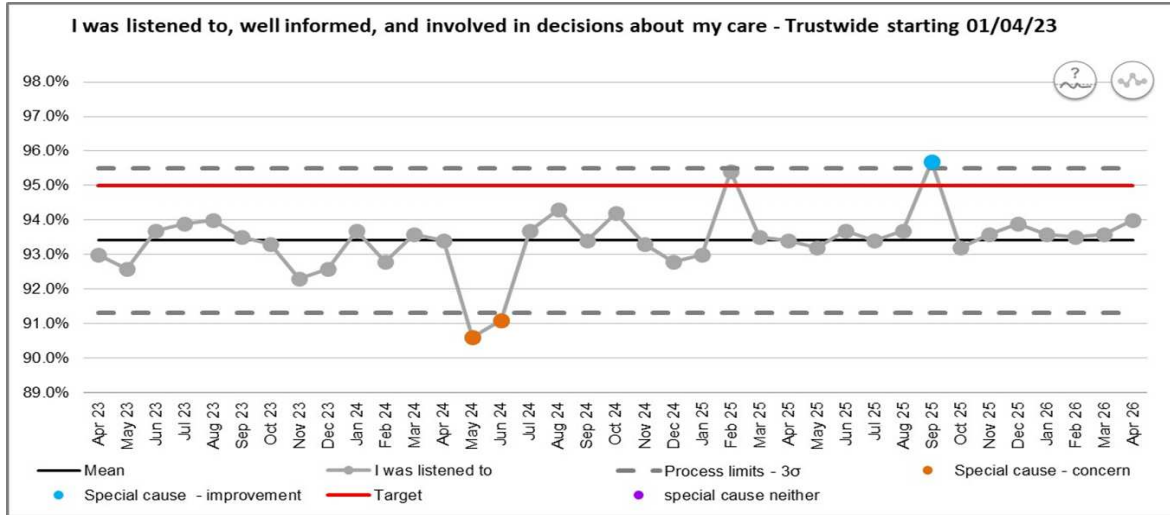
# Strategic objective: Delivering the highest quality care for all

Strategic metric: I was listened to, well informed & involved in decisions about my care

Board Committee: Quality committee

SRO: Chief Nursing Officer

Assurance	Variation



**This measures:** The percentage of patients completing the Friends and Family Test (FFT) Trust-wide who feel that they have been 'listened to and involved in decisions about their care'

**How are we performing:**

- This metric now includes the Trustwide overall FFT Satisfaction score, currently 94.0% for April with a target of 95%
- Trust response rate has dropped from 9.0% in March to 8.1% in April
- Lowest scoring areas for Question 2 in April: Emergency Departments (83.4%) and Paediatric Care (based on parent/carer feedback) (87.4%)
- Complaint acknowledgments and response turnaround remains below target at 68% and 75% respectively

**Actions and next steps:**

- Translate FFT into additional 5 languages (5 currently available). **June 26**
- Review of outpatient clinic names against FFT drop downs **June 26**
- Trial action-driver function in IQVIA with 3 departments to allow real-time direct notification of negative feedback **June 26**
- Review areas consistently scoring low and create action plans Q2 **July 26**
- Roll out new QR poster and comms to prompt FFT completion **June 26**
- Implementation of Quail to support complaints staffing review, acknowledgments and turnaround times. **April 26**
- Complete Trustwide complaints improvement action plan **October 26**
- Work with Care groups to improve complaint response times **June 26**

**Risks:**

- Lack of dedicated AI system for FFT thematic analysis
- Limited FFT information on Workvivo to support specialty queries
- Quail unable to access federated data platform to enable implementation of new complaints system


Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
I was listened to, well informed & involved in decisions about my care (FFT) Q2	93.6%	93.9%	93.6%	93.5%	93.6%	94.0%
Overall Trustwide FFT satisfaction rate	94.2%	94.3%	93.4%	93.5%	93.3%	94.0%
Overall Trustwide FFT response rate	7.8%	6.8%	9.4%	9.4%	9%	8.1%
Number of complaints	51	54	90	71	64	54
Complaints turnaround in 25 days	40%	63%	59%	67%	55%	75%
Percentage complaints acknowledged within 3 days	65%	74%	54%	86%	72%	68%

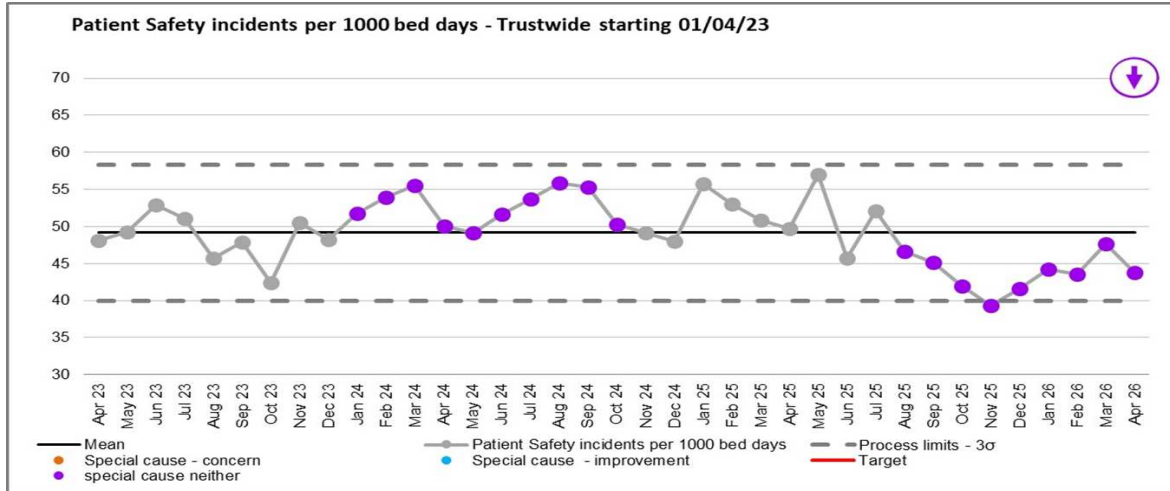
# Strategic objective: Delivering the highest quality care for all

## Strategic metric: Learning from incidents to reduce harm

Board Committee: Quality committee

SRO: Chief Nursing Officer

Assurance	Variation
	



**This measures:** Patient Safety incidents per 1000 bed days across all units. With the change to the patient safety incident response framework (PSIRF) the focus is on the stability of our incident reporting

- How are we performing:**
- The number of incidents per 1000 bed days remains above the minimum threshold of 40 and within to control limits
  - National Patient Safety Syllabus (NPSS) training continues to show an increase

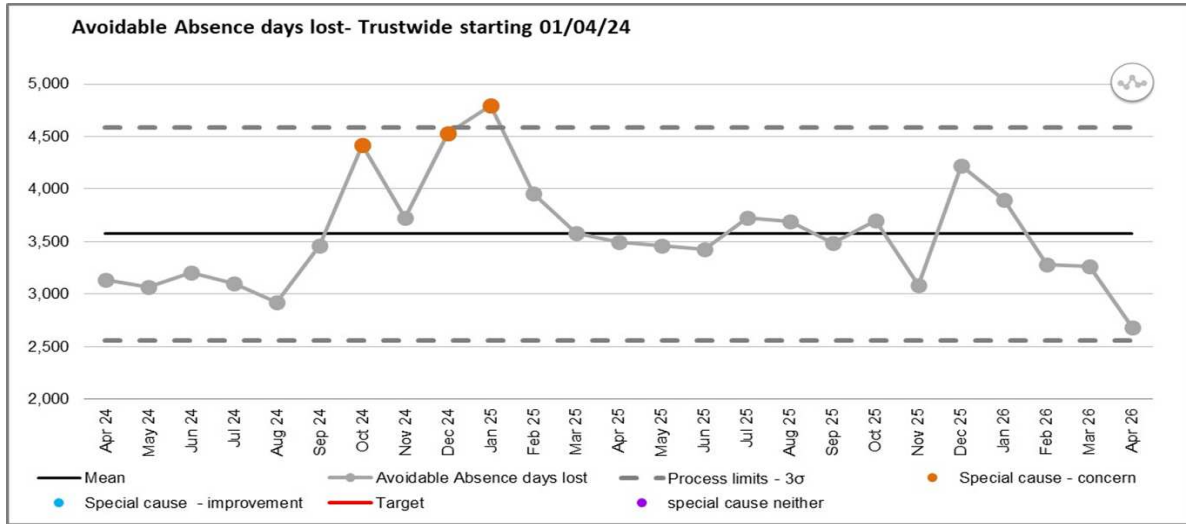
- Actions and next steps:**
- Replacement/upgrade of the Datix system for managing incidents, risk and complaints was out to tender
  - PSIRF priorities and plan have been developed with the care groups and was approved through the Patient Safety Committee in April

- Risks:**
- Number of total staff who have completed NPSS e-learning Level 1 is 41% and Level 2 is 24% (Trust staff). This is a steady upward trend

Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
<b>Patient Safety incidents per 1000 bed days</b>	39.34	41.65	44.27	43.50	47.62	43.76
<b>% total incidents that are low/no harm</b>	96.88%	96.87%	96.89%	97.19%	95.63%	96.26%
<b>No. of Deteriorating patient incidents</b>	10	9	9	5	7	8
<b>FFT question: I felt safe during my visit to the hospital (%)</b>	92.8%	92.1%	90.8%	91.2%	90.3%	91.0%
<b>Total Calls for Concern from patient and family</b>	23	20	30	31	17	22
<b>National Patient Safety Syllabus training compliance</b>	1,162	1,231	1,242	2,602	3,622	4,417

**Strategic objective: Supporting our people to thrive**

**Strategic metric: Reducing avoidable absence**



Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
<b>Avoidable absence in days lost per month</b>	3081	4225	3894	3283	3267	2686
<b>Incidents of violence and aggression</b>	55	75	77	54	64	58
<b>Total number of freedom to speak up referrals</b>	19	4	16	6	11	8
<b>Number staff accessing health prevention offer</b>	-	-	-	130	136	81
<b>Statutory and mandatory training compliance</b>	92.4%	92.8%	92.8%	93.0%	92.8%	92.9%

**Board Committee:** People Committee

**SRO:** Chief People Officer

Assurance	Variation

**This measures:** Avoidable absence, including anxiety, stress, depression, back problems, musculoskeletal problems and cough, colds and flu, measured in days lost per month

**How are we performing:**

- Following a significant spike in days lost due to sickness absence in December, days lost have been steadily reducing and are currently the lowest (best) they have been in the last two years

**Actions and next steps:**

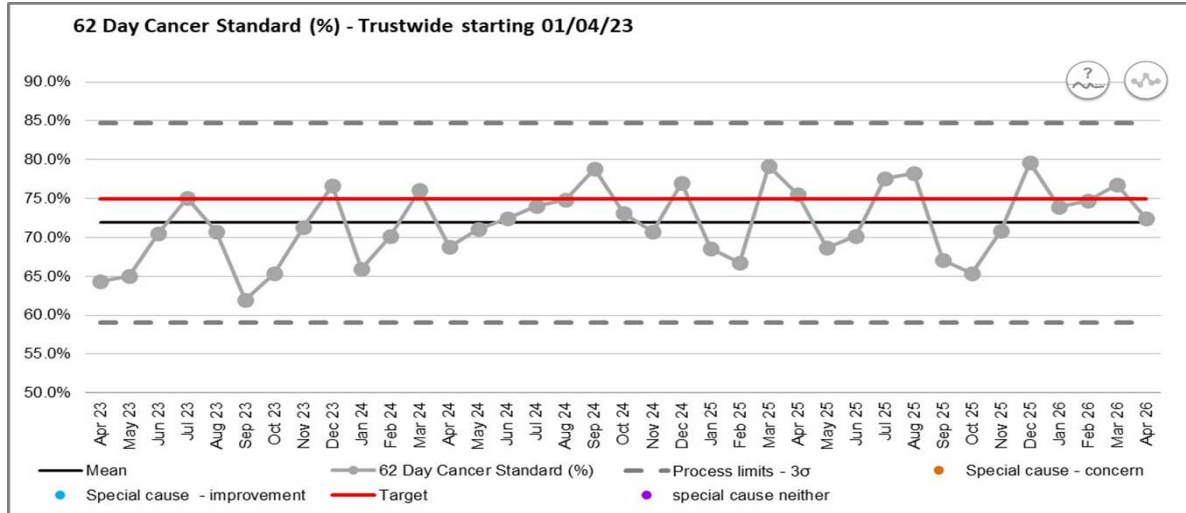
- Staff Survey 2025 Action Plans are now operational, with many departments committed to reducing burnout in their areas
- Information webinars from the E-Rostering and Occupational Health teams have been scheduled for May 2026, to help managers manage sickness absence in their teams. Webinars for leaders in Facilities are currently being arranged
- People and Change Partners are developing their Strategic People Plans for their respective care groups which will outline the key people priorities over the next few years

**Risks:**

- Financial constraints are putting pressure on staffing and other resources. Staff survey results show that unacceptable behaviours from patients are on the rise

## Strategic objective: Partnering for Impact

Strategic metric: Improve waiting times: Reduce waits of over 62 days for Cancer patients



Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Cancer 62 day %	74.1%	79.6%	75.7%	77.8%	78.9%	74.4%
Cancer 62 day % Trajectory	73.0%	74.0%	74.0%	74.0%	75.0%	75.0%
Performance against 28 day faster diagnostic standard (FDS) (%)	80.6%	85.1%	80.0%	85.6%	87.1%	84.0%
31-day cancer standard performance	94.4%	93.0%	89.3%	89.5%	90.9%	88.3%
31-day cancer standard trajectory	N/A	N/A	N/A	N/A	N/A	89.9%
Stage cancer presentation	51.4%	49.8%	51.5%	46.7%	Arrears	Arrears

Board Committee:  
Quality Committee

SRO: Chief Operating Officer

Assurance

Variation



**This measures:** The percentage of patients with confirmed cancer receiving first definitive treatment within 62 days of referral to the Trust. The national target is 85%. Trusts are expected to achieve 80% performance by March 2027

### How are we performing:

- In March 78.9% of patients were treated within 62 days. April's unvalidated performance is 74.4%. This will likely improve post-validation
- The total number of patients on the Patient Tracking List (PTL) waiting over 62 days at the end of April was 176, down from 196 in March. The tumour sites with the most patients on the PTL over 62 days are Urology, Lower Gastrointestinal (LGI) and Gynaecology

### Actions and next steps:

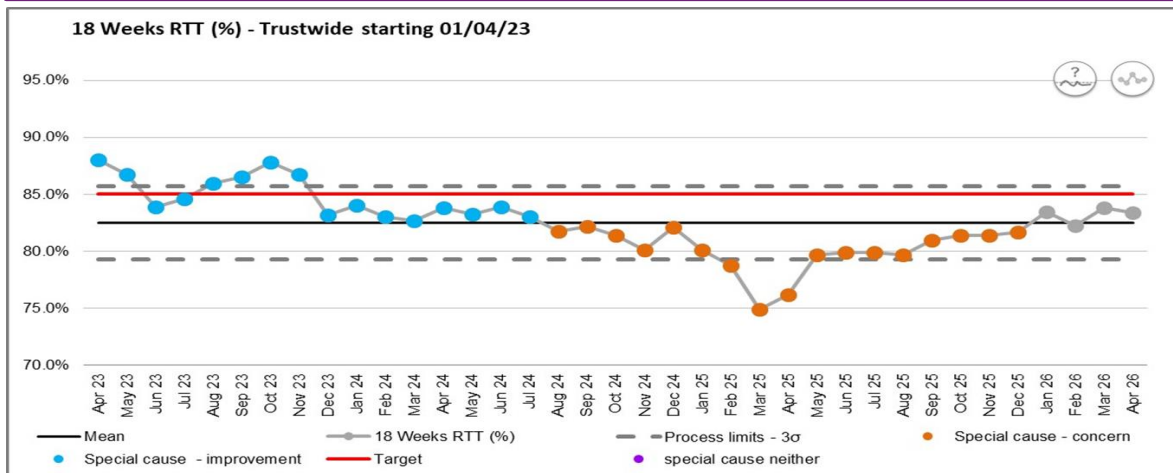
- Gynaecology are focusing on reducing length of wait for patients requiring an inpatient hysteroscopy (IPH) by redesigning the pre-op pathway along with recruiting another locum consultant to support the diagnostic and surgical pathway
- LGI are continuing to enhance their nurse-led triage process as well as reviewing Endoscopy and CT scan pathways to ensure there are no delays in communicating diagnostic results to patients
- Urology are continuing to focus on speeding up the pathway for prostate diagnoses, including implementing additional nurse-led results clinics

### Risks: Corporate Risk 4241

- Continued delays to some parts of pathways in Gynaecology, Gastroenterology and Urology
- High reliance on insourcing/outsourcing

## Strategic objective: Partnering for Impact

Strategic metric: Maximising Elective Activity: Achievement of the <18 week Referral to Treatment (RTT) standard



Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
18 Weeks RTT (%)	81.36%	81.69%	83.45%	82.21%	83.78%	83.40%
Percentage referrals returned with advice to referrer	14.6%	15.3%	14.7%	14.4%	14.9%	14.6%
% plan for first outpatients	31.92%	31.80%	28.96%	29.72%	29.17%	30.80%
% plan for combined daycase and inpatients	97.09%	96.45%	96.56%	96.70%	97.14%	97.14%
% patients waiting less than 6 weeks for diagnostics (DM01)	83.2%	79.3%	79.9%	86.0%	86.8%	77.1%
Number of patients waiting more than 52 weeks for treatment (RTT)	37	45	32	43	40	38

Board Committee:  
Quality Committee

SRO: Chief Operating Officer

Assurance	Variation

**This measures:** Trust performance against the national Referral to Treatment standard (92%). The 2026 National Operating Plan expectation is to achieve 7 percentage point improvement by March 2027 and return to 92% by March 2029. RBFT has submitted intention to comply with these expectations

### How are we performing:

- Performance against the headline RTT standard remains in line with trajectory as a combined result of RTT-specific validation, Master waiting list data cleansing actions, additional activity and increased triage
- For 2026/27 the core focus of recovery actions will be on maximising first assessment activity and driving down first assessment waiting times
- We expect performance to reduce slightly through the early part of the year as triage and validation continue to affect the profile, before improving in the second half of the year. This is in line with the submitted trajectory

### Actions and next steps:

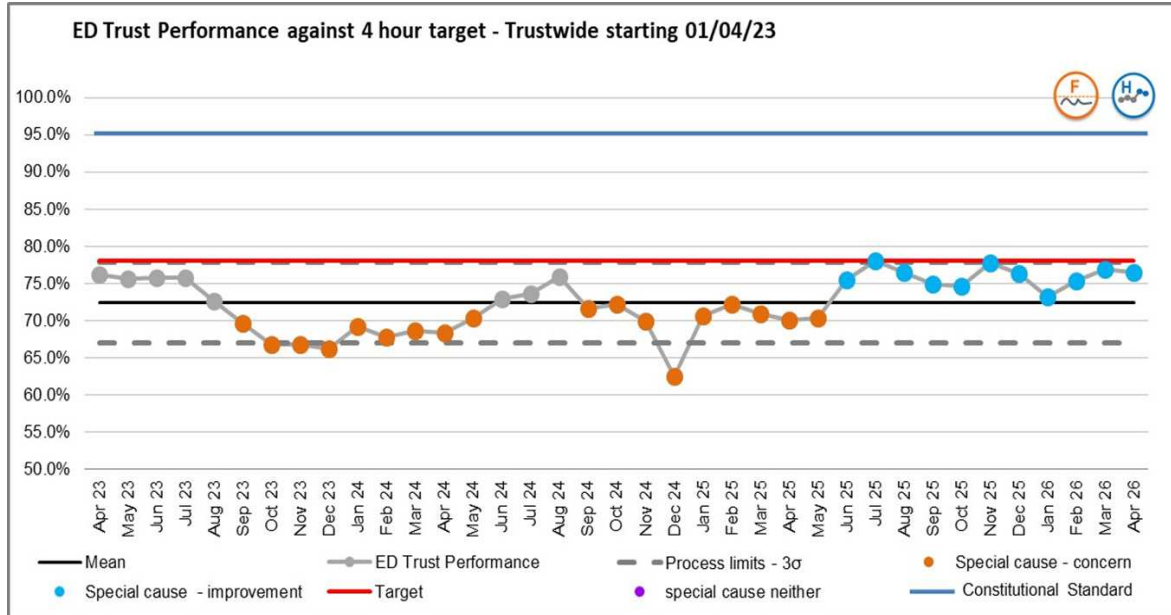
- Continue to drive improvement in the 1st OPA waiting times
- Continue to focus on reducing tip-over demand whilst also driving down the volume of long wait pathways
- Large Language Model Development and Pathways Insight and Coordination Solution (PICS) is well underway. With early results looking promising. Parallel running of PICs is delayed (resourcing) but expected to be available by the summer
- Allocation of TV Innovation Funds to maximise stage of treatment backlog

### Risks: Corporate Risk 5995

- Capacity to sustain performance against standard

## Strategic objective: Partnering for Impact

Strategic metric: Working together: Performance against 4hr Emergency Pathway target



Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
4hour Performance (%)	77.77%	76.36%	73.15%	75.40%	76.93%	76.49%
Average time to Clinician - all arrivals	72	75	82	70	74	74
Number of redirects from ED to Urgent Care Centre (UCC)	1125	1275	1181	1068	1208	1009
Average Handover time (SCAS)	17:19	18:47	24:05	18:16	17:54	18:49
Number of >12hr LOS from arrival in ED (% of total volume)	3.5%	4.3%	8.3%	6.6%	5%	5.5%
Number of >12hr Decision To Admit (DTA) LOS in ED	7	12	11	52	28	16

Board Committee:  
Quality Committee

SRO: Chief Operating Officer

Assurance

Variation



**This measures:** The number of patients experiencing excess waiting times (>4hr) for emergency service. While the constitutional standard remains at 95%, NHS England has set the target of consistently seeing 82% of patients within 4 hours by the end of March 2027

### How are we performing:

- 76.49% all types of patients were seen within 4 hours. Overall growth comparing April 26 to April 25 – 17%
- Type 1 attendances for April, 66.11%, 0.8% improvement from March
- Slight increase in Ambulance handovers >15 mins (46%). Overall demand remains consistent with seasonal pattern, and flat against last year
- Admissions from ED, have increased in April by –5% compared to April 25 despite the best effort Single Point of Access(SPOA) and use of SDEC
- RBFT ED T1 performance for March was 66.11%
- Exit block and downstream capacity/flow limitations – Work continues to address early discharge and improve flow earlier in the day

### Actions and next steps:

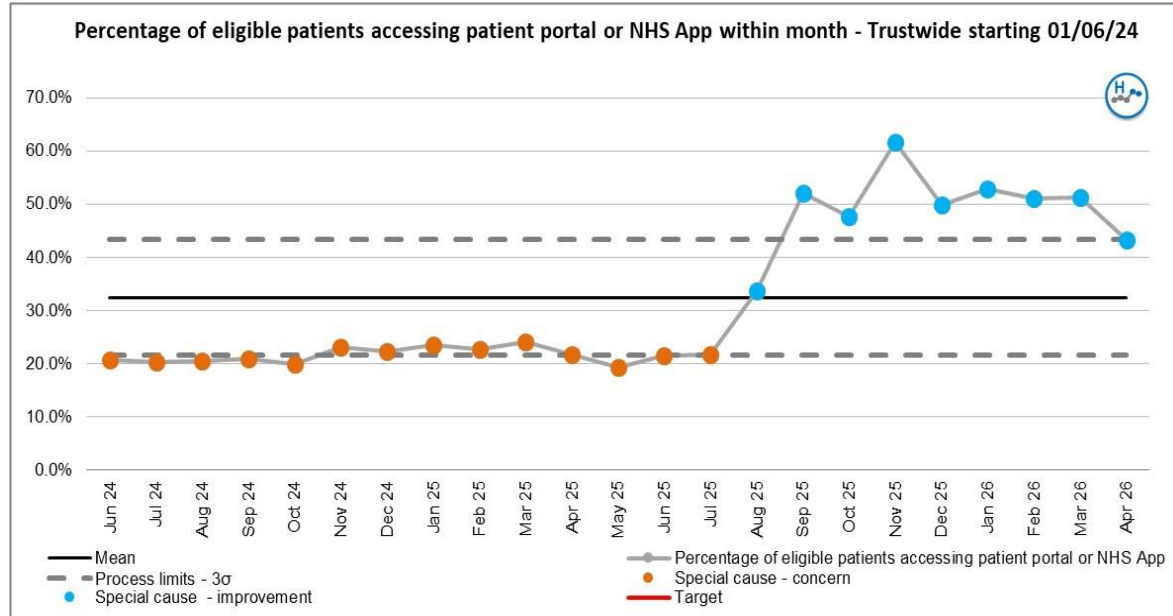
- Reviewing Winter 25/26 actions and refining for 26/27
- Further refining the application of the Temporary Escalation Space Standard Operating Procedure on wards
- Maximising attendance and admission alternatives

### Risks: Corporate Risk 4172

- Significant increase in Mental Health demand & incidences of violence & aggression towards staff; and associated costs; increased LOS
- Demand for ED sustained, above the anticipated UCC volume
- Dependence on specialties to see referred patients in a timely manner

## Strategic objective: Driving improvement and enabling innovation

### Strategic metric: Digitally enabling our patients



Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
% of eligible patients using portal or NHS app within month	61.7%	49.8%	52.9%	51.0%	51.2%	43.3%
% Services live on patient portal or NHS App	-	-	-	-	-	-
Number of logins via NHS App or patient portal	196,734	192,265	241,143	217,206	242,385	223,636
Advice and guidance (A&G) activity	2521	2715	2728	2757	3043	2634

Board Committee  
Quality Committee

SRO: Chief Strategy Officer

Assurance

Variation



**This measures:** The % of eligible patients accessing our patient-facing portal (Royal Berkshire Connect), including via the NHS App

#### How are we performing:

- Adoption rate has remained stable over last five months reflecting stabilisation of invitations after the re-launch of the platform in 2025
- Number of logins per month has increased since last year reflecting larger number of features available in the platform

#### Actions and next steps:

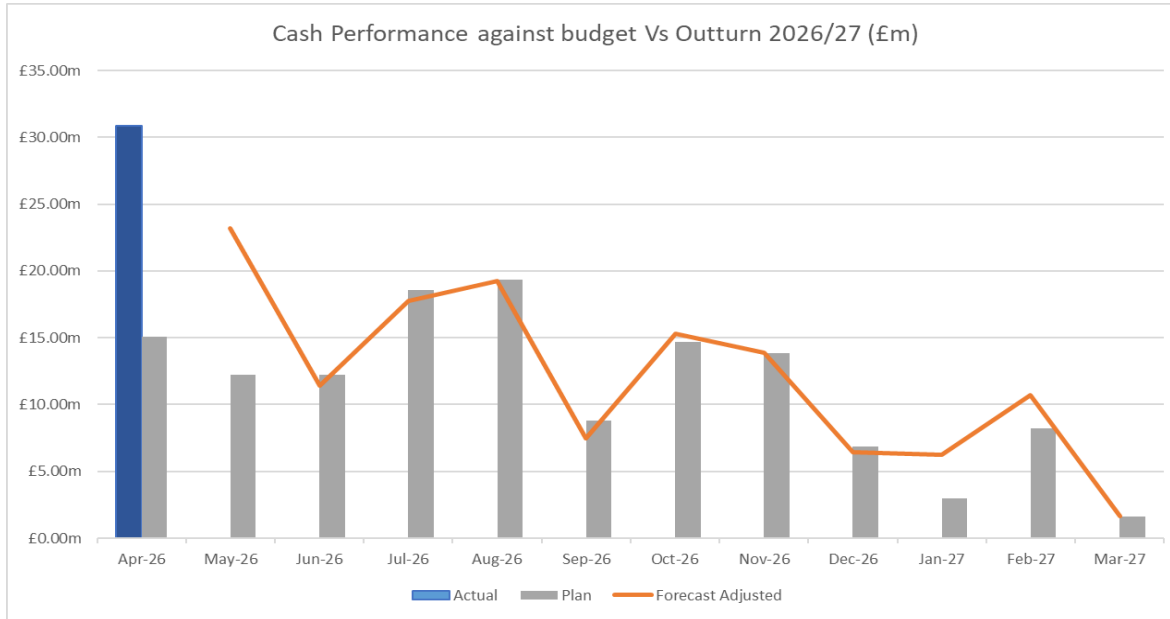
- Website refresh completed and paid / non-paid communications campaign completed with coverage on BBC Radio Berkshire
- Increasing the number of letters that patients can read on the portal
- Allowing patients to use the portal to request support when their condition worsens rather than default follow up timescales (PIFU)
- Add ability for patients to manage their own appointments without any administrative interaction

#### Risks:

- Patient and staff knowledge of what functionality is available in the portal / NHS App is still lower than it could be, which we are mitigating through improved communications

## Strategic objective: Building a sustainable future together

### Strategic metric: Cash position (£)



Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
<b>Cash Performance</b>	£19.72m	£5.35m	£8.01m	£22.52m	£27.04m	£30.85m
<b>Underlying financial position</b>	£(2.19)m	£(6.00)m	£(2.57)m	£(3.04)m	£(3.86)m	£(2.60)m
<b>In-month variance to plan: Pay</b>	£(0.59)m	£(1.15)m	£(1.01)m	£(1.40)m	£(1.39)m	£(0.18)m
<b>In-month variance to plan: Non-Pay</b>	£(0.69)m	£(0.73)m	£(0.85)m	£2.62m	£(2.82)m	£0.72m
<b>In-month WTE (incl bank and agency)</b>	6345	6346	6390	6428	6469	6388

Board Committee  
Finance & Investment

SRO: Chief Finance Officer

Assurance	Variation

**This measures:** RBFT's cash position (M01 - £30.85m)

#### How are we performing:

The cash position in M01 is £30.85m. This is £15.79m ahead of plan. The core drivers are:

- £13.2m clawback has not yet been applied by Thames Valley Integrated Care Board (ICB), this is expected to be processed at the end of Q1
- Berkshire Surrey Pathology Services (BSPS) net payment of £2.3m for Q4 has not been completed yet

#### Actions and next steps:

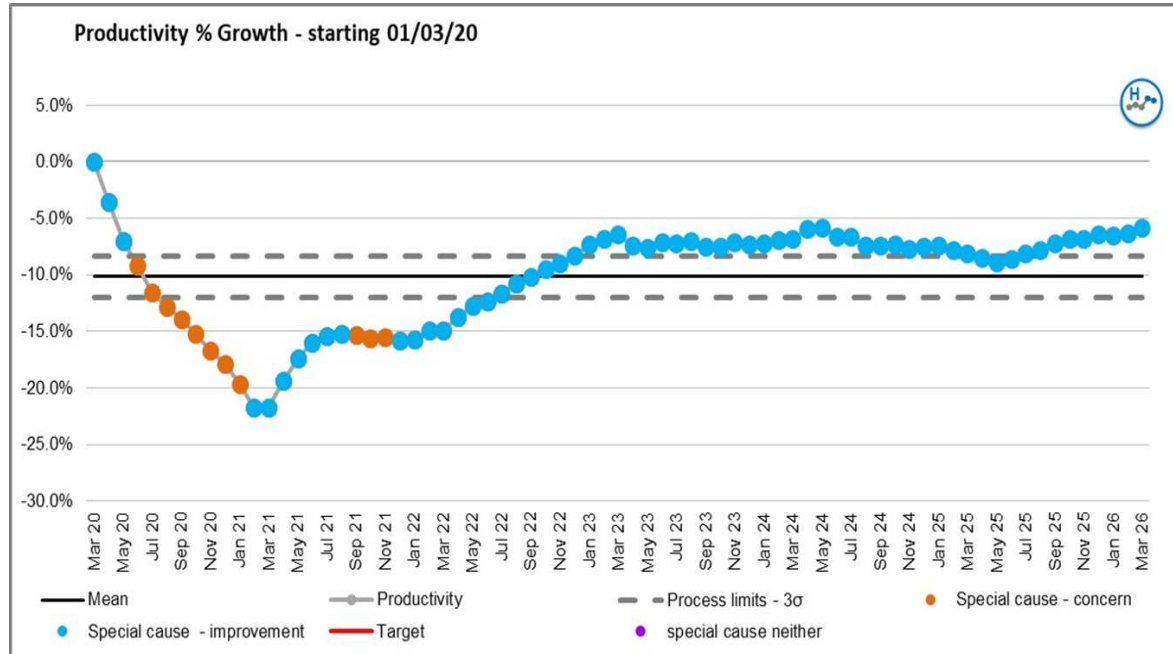
- We continue to closely monitor and manage the cash balances to ensure liquidity remains
- The trust continues with the recovery action including delivery of the breakeven plan and the cash releasing savings to ensure that the cash balances do not deteriorate
- We continue to sustain cash flow agreements with the ICBs

#### Risks:

- The non-delivery of our breakeven plan will lead to shortage of cash
- The non-delivery of WTE CIP as savings delivered are reinvested
- Unable to make timely payment due to liquidity risk
- The Trust has delivered its deficit plan of £(1.12) in M01, whilst impacted by the industrial action cost of £0.47m

## Strategic objective: Building a sustainable future together

### Strategic metric: Productivity Growth Since 2019/20



Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
<b>Productivity % Growth (activity/whole time equivalent)</b>	-6.8%	-6.5%	-6.5%	-6.3%	-5.9%	Arrears
<b>Cost Weighted Activity (CWA) % Growth</b>	14.8%	15.3%	15.1%	15.5%	16.1%	Arrears
<b>Whole Time Equivalent (WTE) % Growth</b>	23.1%	23.2%	23.1%	23.2%	23.3%	Arrears

Board Committee  
Finance & Investment

SRO: Chief Strategy Officer

Assurance

Variation



**This measures:** Productivity, here measured by 'output per worker' in the Trust as approximated by the value of all WTE growth against activity growth year on year. The measure is reported on a 12 month moving average basis to account for seasonal variation

#### How are we performing:

- Since 2021, productivity has continued to improve as the Trust's activity levels returned to and then exceeded 19/20 levels. This trend returned and persisted throughout 2025/26
- In March, the Trust performs 5.9% below 2019/20 levels of productivity as workforce growth (23.3%) exceeds activity growth (16.1%), continuing the positive trend in this metric
- The National outcomes framework indicates RBFT productivity improvement in the last 12 months is in the top quartile of acute trusts with a year-on-year productivity improvement of 6% on the NHSE metric

#### Actions and next steps:

- Teams are working on the identification of their cost improvement plans for 26/27, with around 50% of the total plan identified to date
- In addition, a financial improvement plan is under development with a focus on improving the capture of activity and the delivery of benefits from the Trust's Transformation programmes

#### Risks:

- The Trusts WTE plan for 2025/26 requires teams to make savings aligned to CIP targets. Plans are not yet robust enough to ensure delivery

# Breakthrough Priorities

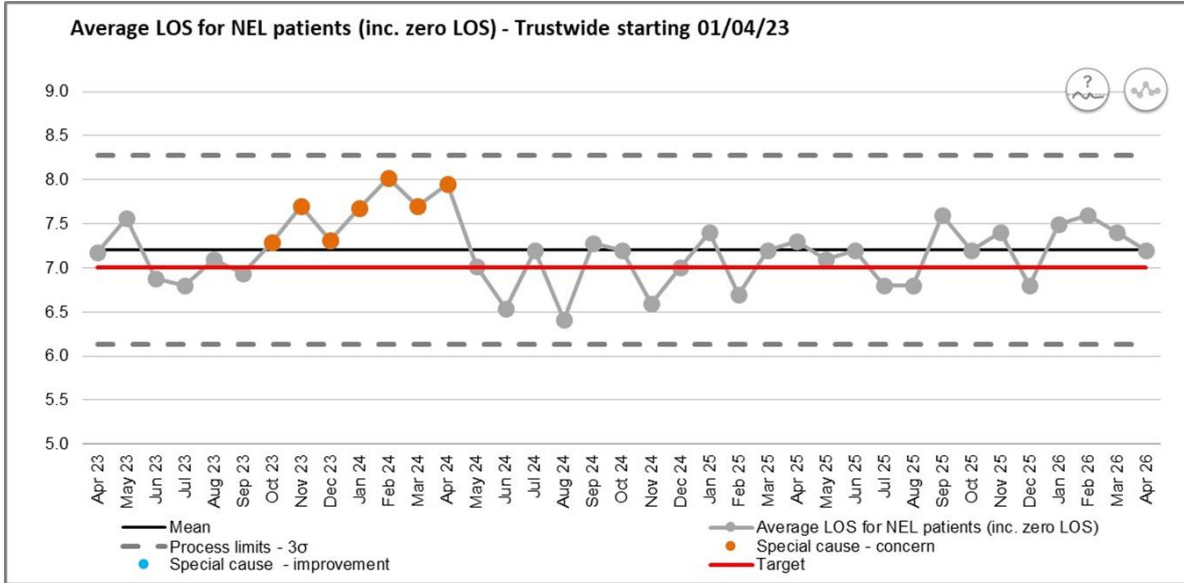
# Breakthrough priority metric: Safest place

## Average Length of Stay (LOS) for non-elective patients

Board Committee: Quality Committee

SRO: Chief Operating Officer

Assurance	Variation



**This measures:** Our objective is to reduce the average Length of Stay (LOS) for non-elective (NEL) patients to:

- Maximise use of our limited bed base for patients that need it most
- Reduce harm from unwarranted longer stays in hospital
- Positively impact ambulance handover times and ED performance

**How are we performing:**

- The average LOS in March was 7.2 days. This is a positive step towards achieving our target of <7 days
- Last achievement was in Dec 25 (6.8 days)

**Actions and next steps**

- Continued drive for improved accuracy of targeted day of discharge, April improved at 55.1% vs the target of 60% (target was achieved for 1 week)
- Continued focus on early use of Discharge Lounge (DL). April saw 43.7% of patients discharged via the DL before midday (target = 50%)
- Usage of the DL improved to 493 patients in March (target = 500) with an improvement of 27 (276) patients before 12pm
- Refining the new process to highlight community bed capacity and demand and identifying patients 1 working day in advance is underway, but difficult to implement, especially over the weekend
- Winter resilience meetings continue with BHFT to ensure visibility of Community Hospital Flow

**Risks:**

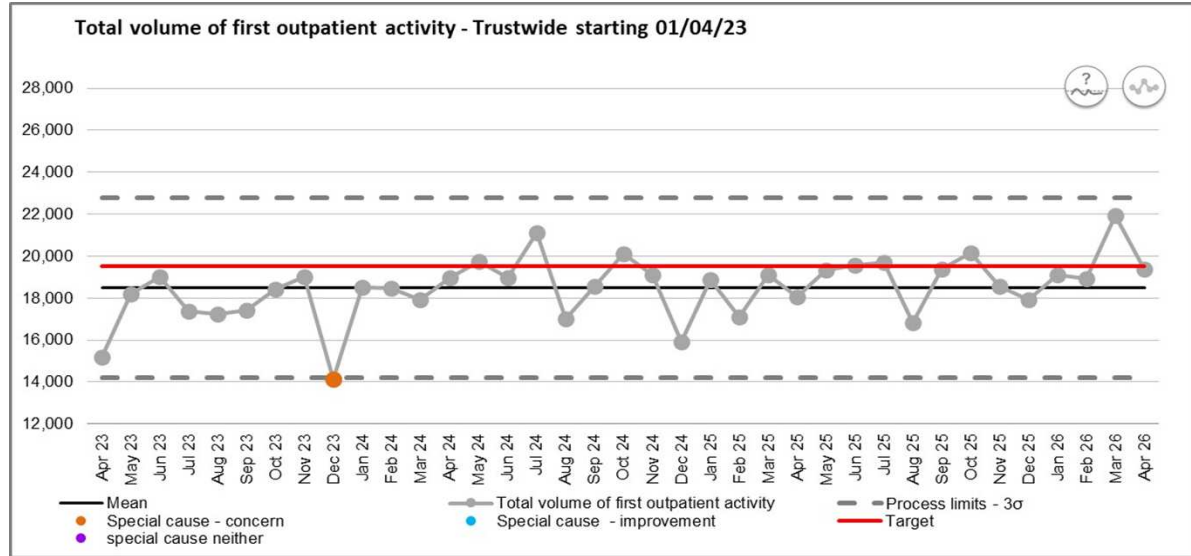
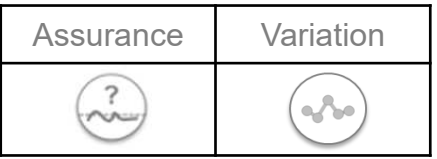
- Winter pressure + increased patient moves / discharge to non-optimal ward
- Ward closures delays patients needing isolation period from going home with care
- Community Hospital ward closures

Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Ave LOS for NEL patients (inc. zero LOS)	7.3	6.8	7.4	7.6	7.3	7.2
Average LOW time for community hospital bed in Berkshire West	3.0	2.9	3.2	4.1	2.8	3.1
P1-3 Average % core inpatients DC Ready	10.7	12.8	12.1	11.6	10.7	9.8
BW Community ave empty beds overnight	9	11	9	12	8	6
BW Days Delays for Social Care packages P1 at home (POC)	4.6	3.3	3.5	3.3	3.9	4.4
BW Days Delays to Health Care packages P1 at home (BHFT/CRT)	1.6	3.7	1.6	2.0	1.6	1.8

# Breakthrough priority metric: Improving elective performance

## Total Volume of first Outpatient (OP) Activity

Board Committee: Quality Committee  
SRO: Andrew Statham



**This measures:** The volume of first outpatient activity (OPA), including outpatient procedures, being undertaken.  
First OPA is the largest and most modifiable aspect of the elective pathway and is the biggest contributor to waiting times delays.  
To support our patients and deliver our financial plan we are seeking to increase our OPA to 19,540k per month

**How are we performing:**

- Completed data for April shows that we delivered 19.4k 1st OPA which is lower than our target for the month. Data is provisional and may increase
- Increase in performance in March was attributable to the OP sprint that took place in March and was separately funded by NHSE

**Actions and next steps**

- Work led by finance and informatics has uncovered areas for improvement in the recording of OP activity which will help us reflect work delivered by teams
- Role of triage in supporting reduction of waiting lists will be discussed at each Care Group Clinical Governance meetings throughout May
- Teams are being encouraged to make use of new e-triage and PIFU tools to support the delivery of individual specialty targets for 1<sup>st</sup> OP

**Risks: Corporate Risk 5698**


- Go-live date for patient initiated follow up through both EPR and Royal BerkshireConnect integration has been delayed, an expected go live date is by the end May 26. A training and communications plan is currently in development

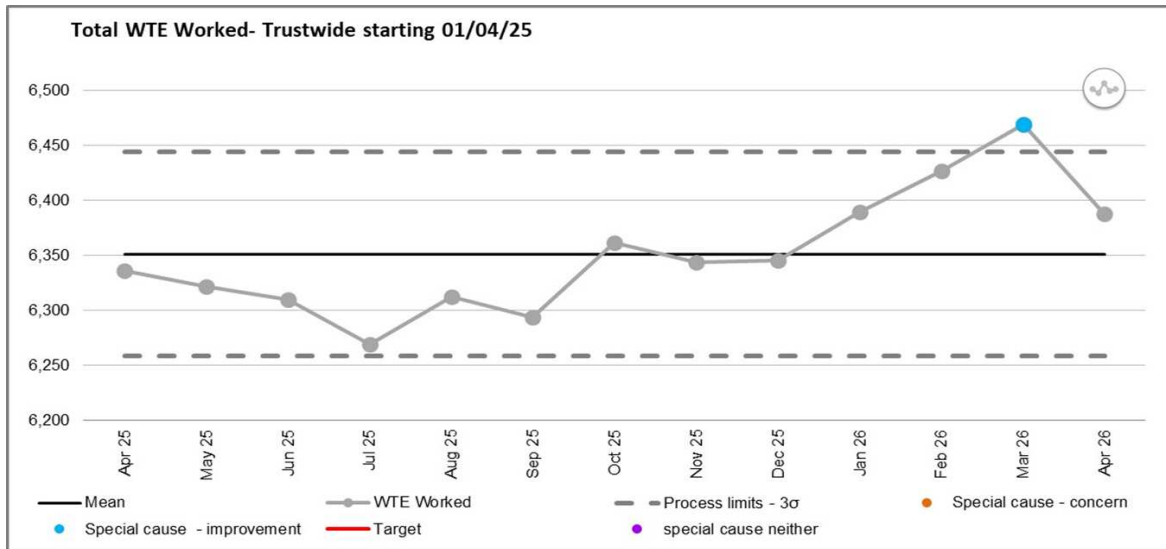
Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Total Volume of first outpatient activity	18,577	17,942	19,097	18,902	21,935	19,359
First outpatient activity Plan	18,536	19,463	19,463	18,536	19,500	19,340
Average wait for first outpatient appointment	68.0	64.7	68.0	71.2	64.5	60.3
% patients waiting over 12 weeks for first assessment	71.50%	75.55%	70.27%	69.39%	68.75%	69.82%
% OP that did not attend/were not brought (1 <sup>st</sup> OP Appt)	8.5%	8.5%	7.9%	7.6%	6.9%	6.5%
% triage within 2 working days for all GP referrals (including 2 week wait, urgent and routine)	46.4%	48.5%	54.3%	56.3%	57.1%	55.2%

## Breakthrough priority metric: Future workforce Rightsized workforce (total wholtime equivalent worked)

Board Committee: Finance & Investment Committee

SRO: TBC

Assurance	Variation
	



**This measures:** the total whole time equivalent (WTE) worked per month.

### How are we performing:

- Month one reduction in total WTE worked, driven by reductions across the board (contracted, bank and agency)

### Actions and next steps:

- Care groups continue to work on Cost Improvement (CIP) schemes to identify recurrent savings
- Workforce controls continue to be refined and improved across Care Groups, Digital Data and Technology and Estates and Facilities. Focus is on wider understanding of the service and efficiencies in ways of working to identify truly necessary vacancies only

### Risks:

- Balancing rightsized workforce with patient safety & experience, activity levels and income and maintaining cancer standards

Insight Metrics	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
<b>Total WTE worked</b>	6344	6345	6389	6427	6469	6388
<b>Contracted worked</b>	6061	6066	6087	6109	6111	6127
<b>Bank</b>	272	270	294	308	346	254
<b>Agency</b>	11	9	8	10	11	7
<b>Internal promotion (all bands) proportion vacancies filled with internal applicants</b>	-	-	-	-	-	-
<b>Stress, anxiety and depression absence (number of days lost)</b>	1359	1779	1399	1194	1395	1233

# Watch Metrics

# Summary of alerting watch metrics

## Introduction:

Across our five strategic objectives we have identified 110 metrics that we routinely monitor, we subject these to the same statistical tests as our strategic metrics and report on performance to our Board committees.

Should a metric exceed its process controls we undertake a check to determine whether further investigation is necessary and consider whether a focus should be given to the metric at our performance meetings with teams.

If a metric be significantly elevated for a prolonged period of time we may determine that the appropriate course of action is to include it within the strategic metrics for a period.

## Alerting Metrics April 2026:

In the last month 16 of the 110 metrics exceeded their process controls. These are set out in the table opposite.

There are no new alerting watch metrics this month.

A number of the alerting relate to the operational pressures experienced in the Trust and the focus being given to enhancing flow and addressing diagnostic and cancer performance is expected to have impact on these metrics as well as the strategic metrics covered in the report above, this includes those relating to cancer, stroke and infection control.

## Delivering the highest quality of care for all

- C.diff (Cumulative – Trust Apportioned) 4 cases against a threshold of 39
- Number of unborn babies on child protection plan remains high
- Complaints turnaround time within 25 days 75% Trustwide
- Patient falls resulting in harm 3

## Supporting our people to thrive

- % of staff from global majority backgrounds in senior AFC Bands 8a and above
- Rolling 12 month Sickness Absence
- Violence, Aggression and Abuse from patients towards staff

## Partnering for Impact

- Proportion of patients with high risk TIA fully investigated and treated within 24 hours
- Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival
- Cancer – Incomplete 104 days
- Diagnostics Waiting < 6 weeks (DM01) (%)

## Building a sustainable future together

- Debtors (£m)
- Cash Position (£m)
- Pay cost vs Budget (£m)
- Better Payment Practice Code
- Income Reporting

# Strategic Objective: Delivering the highest quality care for all

## Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett



Royal Berkshire  
NHS Foundation Trust

Metric	Variati	Assura	Target	Feb-26	Mar-26	Apr-26	Apr-25
Never Events			0	0	0	0	0
Pressure ulcer incidence per 1000 bed days			1.00	0.28	0.29	0.16	0.00
Category 2 avoidable pressure ulcers			5	1	1	0	0
Category 3 avoidable pressure ulcers			0	2	1	2	0
Category 4 avoidable pressure ulcers			0	0	0	0	0
Unstageable avoidable pressure ulcers			0	0	0	0	0
Patient Falls per 1000 bed days			5.00	3.42	4.10	Arrears	3.32
Patient falls resulting in harm (PSIRF methodology applied)			-	0	5	3	2
No. of DOLS applications applied for			-	22	31	36	27
No. of detentions under the MH act to RBH			-	0	3	4	2
% of staff: Safeguarding children L1 training			90.00%	96.80%	96.80%	95.90%	96.90%
No. of child safeguarding concerns by the Trust			-	102	127	146	128
No. of adult safeguarding concerns by the Trust			-	76	75	55	68
No. of safeguarding concerns against the Trust			-	9	8	5	4
Unborn babies on child protection (CP) / child in need plans (CIP)			-	45	57	48	46
C.Diff (Cumulative - Trust Apportioned)			39	48	52	56	5
C.Diff lapses in care			-	2	5	4	0
MRSA Bacteraemia (avoidable)			0	0	0	0	0
E.coli (Trust Apportioned) Bloodstream Infections			-	4	6	6	7
E.coli (Trust Apportioned) Bloodstream Infections (Cumulative)			92	81	87	93	6
MSSA surveillance (trust acquired)			-	6	0	3	2
Hand Hygiene			95.00%	98.64%	94.70%	96.07%	99.08%
VTE inpatient (excluding short stay/maternity) risk assessment / prescription compliance			95.00%	96.80%	97.40%	Arrears	93.30%
Hospital Acquired Thrombosis (HAT) rate / 1000 inpatient admissions			0.00	0.34	1.28	Arrears	1.80
Medication incidents per 1000 bed days			0.00	7.45	7.38	6.52	7.52

# Strategic Objective: Delivering the highest quality care for all

## Watch metrics

SROs: Katie Prichard-Thomas  
Janet Lippett

Metric	Variation	Assurance	Target	Feb-26	Mar-26	Apr-26	Apr-25
No. of compliments			-	40	55	43	-
FFT Satisfaction Rates Inpatients: i.Inpatients			95%	95%	95%	94%	94%
FFT Satisfaction Rates Inpatients: ii.ED			95%	81%	81%	82%	81%
FFT Satisfaction Rates Inpatients: iii.OPA			95%	95%	95%	95%	95%
FFT Satisfaction Rates Inpatients: iv.Daycases			95%	100%	99%	99%	95%
FFT Satisfaction Rates Inpatients: v.Children and Young People			95%	100%	79%	100%	95%
Mixed sex accommodation - breaches			0	283	302	78	278
Myocardial ischaemia National Audit Project (MINAP): Door-to-Balloon target of less than 90 minutes			97%	90%	Arrears	Arrears	88%
Myocardial ischaemia National Audit Project (MINAP): Call-to-Balloon target of less than 120 minutes			86%	67%	Arrears	Arrears	50%
Myocardial ischaemia National Audit Project (MINAP): Call to Balloon target less of than 150 minutes			82%	78%	Arrears	Arrears	100%
No. of Patient Safety Incident Investigations (PSII)			-	1	2	1	2
Number of Rapid Reviews			-	0	0	0	4
No. of After Action reviews			-	0	0	1	1
No. of Multidisciplinary Team (MDT) reviews			-	1	5	4	1
No. of Thematic reviews			-	0	0	0	3
Number of Complaints			-	71	64	54	27
Complaints turnaround time within 25 days (%)			80%	67%	55%	75%	63%
Mortality Metrics	Variation	Assurance	Target	Oct-24	Nov-24	Dec-24	Dec-23
Crude mortality			-	1.20	1.40	1.40	1.60
HSMR			100.0	97.0	98.1	101.0	82.9
SMR			100.0	97.5	98.3	100.2	83.0
SHMI			1.00	1.04	1.04	1.05	1.00

# Strategic Objective: Delivering the highest quality care for all

## Maternity Watch metrics

SROs: Katie Prichard-Thomas  
Janet Lippett

Metric	Variation	Assurance	Target	Feb-26	Mar-26	Apr-26	Apr-25
Deliveries			-	375	419	407	374
Bookings			-	429	488	448	504
% of Inductions of labour			-	24.8%	27.9%	30.2%	30.0%
Perinatal mortality rate (rolling year per 1000 births)			4.84	6.31	5.70	0.00	3.93
Number of occasions MLU service suspended for 4 hours or more			4	Arrears	Arrears	Arrears	2
Midwifery staffing vacancy rate			-	0.0%	0.0%	0.0%	9.5%
Midwifery staffing turnover			14.0%	10.4%	10.4%	0.0%	13.1%
Midwife : birth ratio (utilised workforce)			1.22	1.20	1.22	0.00	01:19
FFT Satisfaction Rates Maternity			95.00%	96.20%	94.00%	93.00%	97.50%
No. of complaints - Maternity			3	1	6	4	1
Complaints response Rate			80.00%	0.00%	0.00%	0.00%	-
Number of Rapid Reviews			-	8	8	0	30
No. of After Action reviews			-	0	0	1	3
No. of Patient Safety Incident Investigations (PSII)			-	1	1	1	0
Percentage of babies born with features associated with potential hypoxia			0.00%	0.26%	0.00%	0.00%	0.53%

## Strategic Objective: Supporting our people to thrive

Watch metrics:

















SRO: Paul da Gama

Metric	Variation	Assurance	Target	Feb-26	Mar-26	Apr-26	Apr-25
% of staff from global majority backgrounds in senior AFC Bands 8a and above			25.00%	23.82%	23.83%	24.15%	20.33%
Rolling 12 month Sickness absence			3.3%	3.7%	3.7%	3.6%	3.8%
% Fill rate of Registered Nurse Shifts (RN)			90.0%	95.2%	95.5%	96.5%	97.1%
% Fill rate of Care Support Worker Shifts (CSW)			90.0%	96.7%	95.6%	97.6%	107.5%
Completed Mandatory Training			90.0%	92.2%	92.8%	92.9%	92.4%
Appraisals			90.0%	88.0%	87.6%	86.9%	89.0%
Nurse Staffing Red Flags			-	52	72	60	37

## Strategic Objective: Supporting our people to thrive

Watch metrics:

SRO: Paul da Gama

Metric	Variation	Assurance	Target	Feb-26	Mar-26	Apr-26	Apr-25
RIDDOR reportable Incidents			-	2	5	0	1
Abuse/V&A (Patient to staff)			-	54	64	58	55
Body fluid exposure/needle stick injury			-	21	24	25	23
Environment Related Incidents			-	15	18	8	12
Conflict Resolution			90%	90%	91%	93.1%	91%
Fire (Annual)			90%	92%	92%	92.7%	92%
Moving and Handling Level 1			90%	95%	95%	94.4%	89%
Moving and Handling Level 2			90%	90%	90%	90.2%	89%
Health and Safety Training			-	96%	95%	95.5%	96%
Slips and Trips			-	2	5	2	2
Musculoskeletal - Inanimate object			-	2	3	2	3
Total non clinical incidents reported			-	242	246	193	221

# Strategic Objective: Partnering for Impact

Watch metrics






SRO: Dom Hardy

Metric	Variation	Assurance	Target	Feb-26	Mar-26	Apr-26	Apr-25
Fractured Neck of Femur: Surg in 36 hours			60.0%	48.0%	49.0%	89.0%	-
Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival			90.0%	72.0%	70.0%	Arrears	62.0%
Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (national target)			80.0%	89.0%	93.0%	Arrears	77.0%
Proportion of people with high risk TIA fully investigated and treated within 24hrs (IPM national target)			90.0%	95.0%	91.0%	Arrears	73.0%
Cancer 31 day wait: to first treatment			96.0%	97.7%	94.6%	93.8%	95.1%
62 Day screen Ref			85.0%	92.3%	73.3%	94.1%	81.8%
Cancer Incomplete 104 days			0	51	54	Arrears	43
Average waiting times in diagnostic (DM01) services			6	1	1	2	3
Diagnostics Waiting < 6 weeks (DM01) (%)			99.0%	86.0%	86.8%	77.1%	93.8%

Strategic Objective: Driving improvement and enabling innovation

Watch metrics

SRO: Andrew Statham

Metric	Variation	Assurance	Target	Feb-26	Mar-26	Apr-26	Apr-25
% OP appointments done virtually			-	19.5%	20.6%	20.5%	20.9%
Number of OPPROC			-	13338	15753	15021	12439
Number of MDT OP			-	813	320	836	821
Number of PIs			-	143	143	171	131
Number of active research trials			-	202	204	363	166
Percentage of Commercial Studies opened < 60 days(from site selection to opening of studies)			-	0.0%	0.0%	23.3%	0.0%

# Strategic Objective: Building a sustainable future together

Watch metrics

SRO: Helen Troalen

Metric	Variation	Assurance	Target	Feb-26	Mar-26	Apr-26	Apr-25
Pay cost vs Budget (£m)			-	-1.40	-26.59	-0.18	-0.31
Non pay cost vs Budget (£m)			-	2.62	-13.45	0.72	0.49
Income vs Plan (£m)			-	0.47	33.48	-0.52	-0.05
Daycase actual vs Plan (£m)			-	-0.13	-0.39	-0.40	0.60
Elective actual vs Plan (£m)			-	-0.30	-0.43	-0.48	-0.20
Outpatients actual vs Plan (£m)			-	0.89	-0.95	0.94	-0.39
Non-elective actual vs plan (£m)			-	-0.14	-2.09	-2.98	-0.35
A&E actual vs plan (£m)			-	0.41	-0.35	-0.04	0.13
Drugs & devices actual vs plan (£m)			-	-0.75	-0.51	-1.19	0.35
Other patient income (£m)			-	-0.07	0.02	-0.08	-0.05
Delivery of capital programme (£m)			-	6.03	16.90	0.10	0.70
Cash position (£m)			-	22.52	27.05	30.85	8.97
Agency spend % of total staff cost (%)			-	0.4%	0.4%	4.1%	0.6%
Creditors (£m)			-	-85.43	-94.89	-93.53	-76.36
Debtors (£m)			-	43.93	35.63	40.35	41.95
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) YTD			95.00%	88.20%	88.00%	85.90%	85.00%
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) In Month			95.00%	85.50%	86.00%	85.90%	85.00%

<b>Title:</b>	<b>Update to Standing Financial Instructions (V9) – Key Changes and Governance Impact</b>
<b>Agenda item no:</b>	8
<b>Meeting:</b>	Board of Directors
<b>Date:</b>	27 May 2026
<b>Presented by:</b>	Frances Khatcherian, Chief Finance Officer
<b>Prepared by:</b>	Helen Troalen, interim Chief Finance Officer

Purpose of the Report	This report provides the Audit and Risk Committee with a summary of the key changes between Version 8.2 of the Standing Financial Instructions (SFIs) and the updated Version 9.0. It sets out the governance and control implications of those changes and seeks the Committee's recommendation to the Board of Directors for approval.
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<b>Report History</b>	Audit & Risk Committee, 13 May 2026
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<b>What action is required?</b>	
Assurance	
Information	
Discussion/input	
Decision/approval	<b>RECOMMEND</b> the updated Standing Financial Instructions to the Board of Directors for approval.

<b>Resource Impact:</b>	
<b>Relationship to Risk in BAF:</b>	SO5 – Building a Sustainable Future Together
<b>Corporate Risk Register (CRR) Reference /score</b>	
<b>Title of CRR</b>	

<b>Strategic objectives</b> This report impacts on (tick all that apply):							
Delivering the highest quality care for all				<b>X</b>			
Supporting our people to thrive				<b>X</b>			
Partnering for impact				<b>X</b>			
Driving improvement and enabling innovation				<b>X</b>			
Building a sustainable future together				<b>X</b>			
<b>Well Led Framework applicability:</b>			Not applicable <input type="checkbox"/>				
1. Leadership	x	2. Vision & Strategy	<input type="checkbox"/>	3. Culture	x	4. Governance	x
SO5. Risks, Issues & Performance	x	6. Information Management	<input type="checkbox"/>	7. Engagement	<input type="checkbox"/>	8. Learning & Innovation	<input type="checkbox"/>
<b>Publication</b>							
Published on website		Confidentiality (Fol)	Private		Public		x

## 1 Background

- 1.1 The Standing Financial Instructions form a core component of the Trust's financial governance framework. They set out the responsibilities, policies, procedures and delegated authorities that underpin financial control and the stewardship of public resources.
- 1.2 Version 9.0 represents a substantive refresh rather than a routine update. The principal drivers are:
  - A need to strengthen financial grip and control in the context of the Trust's financial recovery and increased regulatory scrutiny.
  - The coming into force of the Procurement Act 2023 and the introduction of the Provider Selection Regime.
  - A desire to make the SFIs more accessible and operationally useful for budget holders and staff.
- 1.3 The updated SFIs have been reviewed by the Chief Finance Officer and presented first to the Executive Management Committee. The Audit and Risk Committee is asked to scrutinise the changes and, if satisfied, recommend them to the Board of Directors for approval.

## 2 Summary of Key Changes

### Structural redesign

- 2.1 Version 8.2 is a single linear document in which policy principles, operational guidance and the scheme of delegation sit alongside one another, making it difficult for most staff to identify what is relevant to them.
- 2.2 Version 9.0 has been restructured into:
  - Section One — Overview, covering purpose, responsibilities, delegation and escalation procedures.
  - Section Two — Detailed Guidance, covering the full technical and operational requirements by subject area.
  - A new Quick Guide summarising approval limits and key staff responsibilities in an accessible format.
  - Implication for the Committee: Improved accessibility should support compliance. The Committee should note the risk that staff rely solely on the Quick Guide without consulting the full document; this will be mitigated through the communication and training plan described in Section 6.

## 3 Extension of scope

- 3.1 Version 8.2 applies to employees, temporary staff and agency staff. Version 9.0 extends compliance obligations explicitly to volunteers and to staff employed by third-party organisations who deliver services in the name of the Trust.
  - Implication for the Committee: This is a material extension of scope. It should be reflected in the Trust's arrangements with partner organisations and in volunteer management processes.
- 3.2 Expanded terminology and definitions
  - Version 8.2 contains a brief table of eight definitions. Version 9.0 includes a full glossary of

seventeen defined terms, covering Accountable Officer, Board of Directors, Budget, Budget Holder, Finance and Investment Committee, Funds Held on Trust, Trust Chair and others.

- Implication for the Committee: A richer definitions section reduces ambiguity in interpretation and strengthens the document as an enforceable governance instrument.

### 3.3 Strengthened Chief Finance Officer authority

The revised SFIs significantly strengthen the role of the Chief Finance Officer in maintaining financial control. Key enhancements include:

- Explicit authority to restrict delegated financial authority where there is evidence of poor financial performance or control failure.
- Increased oversight of workforce-related financial decisions, including agency usage and establishment changes.
- Formal requirement for Chief Finance Officer approval of prepayments, non-framework procurement and external funding bids.
- A strengthened role in the training and oversight of budget holders, with authority explicitly conditional on completion of appropriate training.
- Formalised escalation route for all SFI breaches to the Chief Finance Officer and Audit and Risk Committee.
- Implication for the Committee: This represents a material strengthening of the financial governance framework and supports the Trust's financial recovery objectives.

### 3.4 CEO accountability — clarification of statutory obligations

- Version 8.2 describes the CEO as accountable to the Board of Directors. Version 9.0 makes explicit that, as Accountable Officer, the CEO is also accountable to the Secretary of State for Health and Social Care, and that this accountability can be exercised through Parliamentary scrutiny.
- Implication for the Committee: This is not a new legal obligation but its explicit inclusion reinforces the gravity of the Accounting Officer role and the standard to which financial decisions must be capable of being defended.

### 3.5 Escalation and non-compliance

Version 9.0 introduces a dedicated escalation section which was not present in Version 8.2. This establishes that:

- Any instance of non-compliance must be notified to the Chief Finance Officer as soon as it is identified.
- The Chief Finance Officer will investigate all instances and report to the Audit and Risk Committee at the next meeting.
- Disciplinary action up to and including dismissal may result from any breach, including by Executive Directors.
- Where the Chief Finance Officer is suspected of a breach, notification goes directly to the Chief Executive Officer.

- Implication for the Committee: This creates a clear and enforceable accountability chain and gives the Committee a formal, regular mechanism for scrutinising compliance failures.

### 3.6 Approval limits and delegation

Core approval thresholds at senior levels (Chief Finance Officer, Chief Executive, and Board) are unchanged. The following changes are noted at lower levels:

- Capital spend:
  - Lower-tier approval threshold increased from £25,000 to £50,000 at operational level.
  - Stronger requirement for formal business case approval, with explicit alignment to NHSE/DHSC processes regardless of funding source.
- Revenue spend:
  - Approval limits unchanged, but authority is now explicitly conditional on the officer having received appropriate training to the satisfaction of the Chief Finance Officer.

Charitable funds — the tier structure has been substantively redesigned:

Tier	Version 8.2	Version 9.0
<b>Lowest</b>	£500 — One Fund Advisor	£1,000 — Two Fund Advisors
	£5,000 — Two Fund Advisors	£10,000 — Three Fund Advisors and Charity Director
	£25,000 — One Fund Advisor Panel member and Charity Director	£50,000 — All above plus Care Group Manager/Matron and Charity Grants Panel
	£50,000 — Care Group Manager/Director/Matron and Charity Grant Panel	£90,000 — All above plus Care Group Director or Executive Director and Charity Committee
	£250,000 — Charity Director	(threshold removed — subsumed into tiers above)
<b>Upper (unchanged)</b>	£1,500,000 — CFO £2,499,999 — CEO Above £2,500,000 — Board	£1,500,000 — CFO £2,499,999 — CEO Above £2,500,000 — Board

- Implication for the Committee: The charity tier changes introduce greater flexibility at lower levels alongside new governance checks at higher values. The Committee should satisfy itself that the Charity Committee has been sighted on these changes.

### 3.7 Procurement and regulatory compliance

- Version 9.0 updates the procurement framework to reflect legislation and guidance now in force:
- Explicit reference to and compliance with the Procurement Act 2023 (which replaced the Public Contract Regulations 2015 for new procurements from October 2024).

- Reference to the Provider Selection Regime, applicable to healthcare service contracts.
- Strengthened requirements for competitive tendering, justification of non-competitive procurement and procurement involvement in all contracting processes.
- Stronger governance around consultancy procurement.
- Implication for the Committee: The change in legislative framework is material. Non-compliance with the Procurement Act carries increased transparency obligations and legal risk. The Trust's procurement team should confirm that operational processes have been updated to reflect these requirements.

### 3.8 Strengthened financial controls

A number of specific new controls have been introduced:

- Prepayments — explicit prohibition on any contract requiring payment in advance of receipt of goods or services without written Chief Finance Officer approval.
- Order splitting — explicit prohibition on splitting orders to circumvent procurement thresholds.
- Anti-money laundering — cash handling procedures updated to reference anti-money laundering thresholds for the first time.
- Fraud reporting — clearer escalation processes for suspected fraud, with explicit timelines and responsibilities.
- Implication for the Committee: These controls address specific risk areas and should provide stronger audit assurance. Internal Audit should be sighted on the new prohibitions as areas for testing.

## 4 Overall Assessment

The transition from Version 8.2 to Version 9.0 is a substantive refresh of a governance document that had not been structurally reviewed since its original design. The key themes are:

- Strengthened financial control and governance, particularly through an enhanced Chief Finance Officer role.
- Alignment with updated regulatory and procurement requirements now in force.
- Improved usability and clarity for staff across all levels.
- Targeted increases in lower-level delegation, balanced by stronger oversight and governance at higher levels.

The revised SFIs are expected to improve financial discipline, enhance transparency and reduce the risk of control failures. They provide the Trust with the mechanisms it needs to intervene decisively where compliance or financial performance falls short.

## 5 Recommendation

The Audit and Risk Committee is asked to:

- Note the key changes to the Standing Financial Instructions and the governance implications set out in this paper.
- Satisfy itself that the scope of changes is appropriate and that material risks have been identified.

- Recommend the updated Standing Financial Instructions (Version 9.0) to the Board of Directors for approval.

## 6 Next Steps

Action	Owner	Target date
Board approval of Version 9.0	Chief Finance Officer	Next Board meeting following this Committee
Publication on Trust intranet and policy library	Director of Finance	Within 5 working days of Board approval
All-staff communication (email from CFO, intranet announcement)	Chief Finance Officer	Within 10 working days of Board approval
Targeted briefing for budget holders and eproc authorised officers	Director of Finance / Finance Business Partners	Within 4 weeks of Board approval
Certification process — all budget holders and eproc authorised officers to confirm they have read and understood the SFIs	Director of Finance	Within 8 weeks of Board approval
Update procurement team on Procurement Act 2023 compliance obligations	Head of Procurement	Prior to Board approval
Internal Audit — incorporate new controls (prepayments, order splitting, anti-money laundering) into annual audit plan	Head of Internal Audit (for agreement with CFO)	Next audit planning cycle
Compliance reporting — first report on SFI breaches under new escalation framework to Committee	Chief Finance Officer	Next Audit and Risk Committee meeting after implementation

## Appendix A — Summary of Key Changes: Version 8.2 vs Version 9.0

*This table provides a concise side-by-side comparison of the principal changes. It should be read in conjunction with the main paper.*

Area	Version 8.2 (current)	Version 9.0 (proposed)
<b>Document structure</b>	Single linear document; all sections combined.	Restructured into Section One (Overview) and Section Two (Detailed Guidance), plus a new Quick Guide summarising approval limits and key responsibilities.
<b>Scope — who must comply</b>	Employees, temporary and agency staff.	Extended to include volunteers and staff employed by other organisations delivering services in the Trust's name.
<b>Definitions / terminology</b>	Brief table of 8 definitions (CEO, CFO, HMRC, PO, Employee, Officer, Scheme of Delegation, Contract).	Full glossary of 17 defined terms, including Accountable Officer, Board of Directors, Budget, Budget Holder, Finance and Investment Committee, Funds held on trust, and Trust Chair.
<b>CEO accountability</b>	CEO accountable to Board of Directors.	CEO accountability now explicitly extends to the Secretary of State for Health and Social Care, reflecting statutory Accountable Officer obligations.
<b>CFO authority</b>	CFO responsible for financial policies and control.	Significantly strengthened: CFO can now formally restrict delegated authority where there is evidence of poor financial performance. New explicit requirements for CFO approval of prepayments, non-framework procurement, and external funding bids.
<b>Escalation &amp; non-compliance</b>	Breaches to be investigated; disciplinary action possible. Reported to CFO and Audit and Risk Committee.	Dedicated escalation section added. All breaches must be reported to CFO immediately. CFO reports to Audit and Risk Committee at the next meeting. Explicit provision where the CFO is the subject of a suspected breach (reported to CEO).
<b>Capital spend — lower tier</b>	Up to £25,000: CIG Chair and others delegated by Operational Heads.	Increased to up to £50,000: as delegated by respective Operational Heads.
<b>Revenue spend</b>	Approval limits as set by Care Group Directors and Corporate Heads.	Limits unchanged, but authority is now explicitly conditional on the officer having received appropriate training to the satisfaction of the CFO.
<b>Charity spend — lower tiers</b>	Up to £500: One Fund Advisor. Up to £5,000: Two Fund Advisors. Up to £25,000: One Fund Advisor Panel member and Charity Director. Up to £50,000: Care Group Manager/Director/Matron and Charity	Up to £1,000: Two Fund Advisors. Up to £10,000: Three Fund Advisors and Charity Director. Up to £50,000: All above plus Care Group Manager/Matron and Charity Grants Panel. Up to £90,000: All above plus Care Group Director or Executive Director and Charity

	Grant Panel. Up to £250,000: Charity Director.	Committee. (Upper tiers: CFO/CEO/Board unchanged.)
<b>Prepayments</b>	Not explicitly addressed.	Explicit prohibition: no contract may require payment in advance of receipt of goods or services without written CFO approval.
<b>Order splitting</b>	Not explicitly addressed.	Explicit prohibition on splitting orders to avoid procurement thresholds.
<b>Procurement legislation</b>	References Public Contract Regulations 2015 and the Procurement Bill 2023.	Updated to reflect the Procurement Act 2023 (now in force) and the Provider Selection Regime.
<b>Anti-money laundering</b>	Not referenced.	Cash handling procedures updated to reference anti-money laundering thresholds.



# Standing Financial Instructions (CG101)

Approval Group	Chair of Committee Job Title	Date
Executive Management Committee	Chief Executive Officer	27/04/2026
Audit & Risk Committee	Chair Non-Executive Director	13/05/2026
Board	Chair, Board of Directors	27/05/2026

## Change History

Version	Date	Author	Reason
Version 8.2	March 2025	Charlene Sables	Update of existing version
Version 9.0	May 2026	Frances Khatcherian	Full refresh to amend structure, update approval limits (including charity limits) and delegation, update for Procurement Act requirements, addition of a quick guide for users

Author:	Frances Khatcherian	Date:	May 2026
Job Title:	Chief Finance Officer	Review Date:	May 2027
Policy Lead:	Chief Finance Officer	Version:	9.0
Location:	Corporate Governance shared drive – CG101		

## Contents

### Section one - Overview

1. Introduction
2. Terminology
3. Responsibilities and delegation
4. Escalation Procedures for Non-Compliance
5. Quick guide

### Section Two - Detailed Guidance

1. Audit
2. Allocations, Business Planning, Budgets, Budgetary Control and Monitoring
3. Annual Accounts and Reports
4. Bank Accounts
5. Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments
6. NHS Service Agreements for the Provision of Services
7. Terms of Service, Allowances and Payment of Members of the Board of Directors and Executive Committee and Employees
8. Non-Pay Expenditure
9. Capital Investment, Managed Service Contracts, Private Financing, Fixed Asset Registers and Security of Assets
10. Tendering and Contracting Procedure
11. Stores and Receipt of Goods
12. Disposals and Condemnations, Losses and Special Payments
13. Patients' Property
14. Hospitality
15. Investments
16. Retention of Documents
17. Taxation and Excise Duties

Author:	Frances Khatcherian	Date:	May 2026
Job Title:	Chief Finance Officer	Review Date:	May 2027
Policy Lead:	Chief Finance Officer	Version:	9.0
Location:	Corporate Governance shared drive – CG101		

## Section One - Overview

### 1. Introduction

#### 1.1. Purpose

- 1.1.1 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Foundation Trust (including its subsidiary and charity), its directors, staff, officers and agents in relation to all financial matters.
- 1.1.2 These SFIs explain the financial responsibilities, policies, processes, and procedures adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages its finances.
- 1.1.3 The SFIs contribute to an overall culture of financial grip and control with all staff having clear roles and responsibilities in relation to managing resources well whilst also delivering safe and effective care.
- 1.1.4 The SFIs apply to all staff (substantive, bank and agency), including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Royal Berkshire NHS Foundation Trust. **Failure to comply with standing financial instructions and standing orders is a disciplinary matter that could result in dismissal.**
- 1.1.5 They do not provide all the detailed procedural advice. These statements must therefore be read in conjunction with the detailed financial procedure notes and other policies referred to within this document. All Trust policies are available on the Trust internal website or from the finance function.
- 1.1.6 All financial responsibilities, policies, processes and procedures relating to the Trust and subsidiaries must be approved by the Chief Finance Officer.

#### 1.2. Authority and compliance

- 1.2.1 These SFIs have been compiled under the authority of the Board of Directors of the Foundation Trust. They have been reviewed by the Trust Audit and Risk Committee and by the full Board of Directors and have their full approval. All staff employed by the Trust will comply with these instructions at all times. Failure to comply will result in disciplinary action up to and including dismissal. These SFIs supersede all previous editions.

Author:	Frances Khatcherian	Date:	May 2026
Job Title:	Chief Finance Officer	Review Date:	May 2027
Policy Lead:	Chief Finance Officer	Version:	9.0
Location:	Corporate Governance shared drive – CG101		

- 1.2.2 All breaches of these regulations, including evidence of fraud or irregularity will be investigated in accordance with the Trust’s Human Resources and Local Counter Fraud Policy (CG155). Any significant breaches of Financial Regulations will be referred to the Chief Finance Officer and the Audit and Risk Committee. The Chief Finance Officer will consider the necessary course of action, which may in certain circumstances include taking disciplinary action.
- 1.2.3 In the event that a staff or Board member becomes aware of an irregularity or breach of any of the SFIs, or systematic breach or abuse of the levels of delegated authority and is concerned about the reporting or notification of such actions through the normal management channels, the Trust has a clear ‘Raising Concerns at Work (Whistleblowing) Policy (CG055)’ on the intranet which should be followed in such circumstances.
- 1.2.4 All such matters will be reported to Audit and Risk Committee by the Chief Finance Officer.
- 1.2.5 Wherever the title Chief Executive Officer, Chief Finance Officer, or other nominated officer is used in these instructions, it should be deemed to include such other officers who have been duly authorised to represent them.
- 1.2.6 However, it is a fundamental tenet of these instructions that no officer of the Trust is empowered in any way to provide authorisation to represent themselves to persons who are not under their organisational control, unless specifically authorised within these SFIs.

### 1.3. Certification

- 1.3.1 All **Officers** with One Advanced eProcurement system (EPROC) authority and all **Officers** who are budget holders will be required to certify that they have read, understood and will comply with these SFI’s.

## 2. Terminology

- 2.1 Any expression to which a meaning is given in Health Service Acts, or in Directions made under the Acts, shall have the same meaning in these instructions:

**“Accountable Officer”** means the NHS Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For the Trust it shall be the Chief Executive;

Author:	Frances Khatcherian	Date:	May 2026
Job Title:	Chief Finance Officer	Review Date:	May 2027
Policy Lead:	Chief Finance Officer	Version:	9.0
Location:	Corporate Governance shared drive – CG101		

**“Audit and Risk Assurance Committee”** means a committee whose functions are concerned with the arrangements for the establishment and maintenance of an effective system of governance, risk management and internal control;

**"Board of Directors"** means the Trust Chair, Executives and Non-Executive Directors of the Trust collectively as a body;

**"Budget"** means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

**"Budget Holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation;

**"Chief Executive"** means the Accountable Officer of the Trust;

**“Committee”** means a committee created and appointed by the Board of Directors to whom responsibilities are delegated;

**“Director”** means a person appointed as a Director in accordance with the constitution. The Directors of the Trust will be:

**“Executive Director”** means an officer of the Trust. Up to five will be voting members of the Board of Directors, appointed in accordance with the Trust

**"Non-Executive Director"** means a member of the Trust

**“Chief Finance Officer”** means the chief finance officer of the Trust;

**“Finance and Investment Committee”** means the committee whose functions are concerned with the arrangements for the preparation and content of strategic and business plans. Monitor financial performance and operational delivery against plans.

**“Funds held on trust”** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers set out under the NHS Act 2006, as amended. Such funds may or may not be charitable;

**"Legal Advisor"** means the properly qualified person appointed by the Trust to provide legal advice;

**"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust;

**“Trust”** means Royal Berkshire NHS Foundation Trust.

**“Trust Chair”** is the person appointed by NHS England to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “the Trust Chair of the Trust shall be deemed to include the Vice-Chair of the Trust if the Trust Chair is absent from the meeting or is otherwise unavailable.

Author:	Frances Khatcherian	Date:	May 2026
Job Title:	Chief Finance Officer	Review Date:	May 2027
Policy Lead:	Chief Finance Officer	Version:	9.0
Location:	Corporate Governance shared drive – CG101		

### 3. Responsibilities and Delegation

- 3.1. The Board of Directors exercises financial supervision and control by:
- 3.1.1 formulating and approving the financial strategy;
  - 3.1.2 requiring the submission and approval of budgets that deliver the financial target set for the Trust within approved allocations and overall income;
  - 3.1.3 defining and approving essential features in respect of important procedures and financial systems including the need to obtain value for money; and
  - 3.1.4 defining specific responsibilities placed on members of the Board of Directors and employees as indicated in the Scheme of Delegation document.
- 3.2. The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session.
- 3.3. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.
- 3.4. Within the Standing Financial Instructions, it is acknowledged that the Chief Executive Officer is ultimately accountable to the Board of Directors, and as Accountable Officer, to the Secretary of State for Health and Social Care, for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Trust Chair and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.
- 3.5. The Chief Executive Officer and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.
- 3.6. It is a duty of the Chief Executive Officer to ensure that existing members of the Board of Directors and employees and all new appointees are notified of, and **understand**, their responsibilities within these Standing Financial Instructions.
- 3.7. The Chief Finance Officer is responsible for:
- 3.7.1 implementing the Trust's financial policies and for coordinating any action necessary to further these policies;
  - 3.7.2 maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of

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separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

3.7.3 ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

3.8. Without prejudice to any functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

3.8.1 the provision of financial advice to the Trust and its employees;

3.8.2 the design, implementation and supervision of systems of internal financial control; and

3.8.3 the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

3.9 All staff, including members of the Board of Directors, severally and collectively, are responsible for:

3.9.1 the security of the property of the Trust;

3.9.2 avoiding loss;

3.9.3 exercising economy and efficiency in the use of resources; and

3.9.4 conforming to the requirements of Standing Orders, Standing Financial Instructions, financial procedures and the Scheme of Delegation.

3.10 Any contractor (including temporary contractors) or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions.

3.11 The Board of Directors acts as corporate trustee for all charitable funds. The Board of Directors delegates the management of the charitable funds to the Charity Committee.

3.12 The Board of Directors are responsible for ensuring appropriate governance arrangements are in place for the Trust's wholly owned subsidiary company, Healthcare Facilities Management Services Limited.

3.13 For any and all members of the Board of Directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board of Directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

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## 4 Escalation Procedures for Non-Compliance

- 4.1 Any instance of non-compliance with Standing Financial Instructions must be notified to the Chief Finance Officer as soon as it has been identified.
- 4.2 The Chief Finance Officer will investigate all instances and report the detailed circumstances of each to Audit and Risk Committee at its next meeting.
- 4.3 Any breach of the SFIs, including by executive directors, could result in disciplinary action, up to and including dismissal.
- 4.4 With reference to other relevant Trust policies, and with appropriate advice from the Chief People Officer, the Chief Finance Officer will determine what disciplinary or other action, if any, is necessary.
- 4.5 If the Chief Finance Officer is suspected of breaching Standing Financial Instructions, then this should be notified to the Chief Executive Officer who will similarly take action identified above.

## 5 Quick Guide

This “quick guide” broadly outlines the responsibilities of all staff in relation to the management of resources along with a summary of the financial approval limits. The “quick guide” must be read in conjunction with detailed guidance and should not be relied upon alone.

### 5.1 Corporate responsibilities of all Trust employees and staff:

- 5.1.1 The SFIs set out specific Trust policies and procedures across a number of areas and all **officers** must comply with these requirements in all cases. Where exceptions are deemed necessary, prior approval from the **CFO** must be obtained, as set out in the SFIs.
- 5.1.2 It is not possible to govern all the financial affairs of the entire Trust through a single set of instructions. Therefore, these Instructions make reference in a number of areas where it is considered appropriate for the **CEO** or the **CFO** to develop, on behalf of the Trust, a series of detailed policies, procedures and processes, which are not included in these Instructions. In such cases it is the responsibility of all **employees** of the Trust to ensure they understand fully the existence, contents and requirements of all such policies and procedures and to comply with them on the basis that they have received full authority from the Board of Directors.
- 5.1.3 Guidance on the existence and relevance of policies and procedures to specific situations is available on the Trust’s internal website or is available from the **CEO**,

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the **CFO** or the Director of Finance. If you are unsure as to the most appropriate course of action in a particular situation then consult one of these sources, especially so if you are about to make a financial commitment on behalf of the Trust, because breach of these requirements will be regarded as a disciplinary offence.

## 5.2 You have a duty of stewardship:

5.2.1 Proper stewardship requires value for money to be high on the agenda of the Board of Directors and all officers.

5.2.2 The next section sets out at a high level what every member of staff must and must not do. This is not exhaustive and must be read in conjunction with the detailed guidance.

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- **Safeguard the Trust’s financial resources.** Financial resources may take the obvious tangible form of fixed assets, income and cash as well as others that are less clear, such as lost or foregone income through failure to notify income sources or lost opportunities to earn or recover income due to the Trust.
- **Conduct Trust business as efficiently, effectively and economically** as possible.
- **Comply with the Trust’s policies and processes** covering all aspects of money, assets and other Trust resources.
- **Report all new income sources** immediately to the **CFO**.
- Inform the **CFO** promptly of any and all money due arising from transactions which they deal with, including contracts, leases, tenancy agreements, private patients and other transactions.
- **report damage to or losses** of the Trust’s premises, assets, supplies or other resources must be reported to the **CFO** immediately in accordance with procedures of Losses and Special Payments.
- Inform either the **CFO** or the Local Counter Fraud Officer if you discover or suspect a loss that you think may be fraud. You should fully understand the Trust’s Human Resources and Local Counter Fraud Policy (CG155).
- **Send all signed copies of contracts** (however described) so that they are lodged with Procurement within one month of formal approval.
- Only order goods and services through the Trust’s Approved Procurement Systems (unless authorised in writing by the CFO to do otherwise).
- Upon delivery of goods or services immediately record the receipt on the relevant Trust Approved Procurement System.
- Quote a valid Trust PO number to suppliers when placing an order for goods or services.
- Comply with the Trust’s Guidance on Hospitality, Gifts & Commercial Sponsorship.
- Obtain approval from the CFO before submitting bids for funding to external bodies, eg NHS England or charitable organisations
- Obtain approval from the CFO before submitting bids to undertake work currently commissioned to another provider in whole or in part

- **Incur expenditure for which there is not an approved budget**, unless authorised to do so by the **CFO, CEO**, or Board of Directors, as appropriate.
- **Use a budget for a purpose other than that for which it was provided**, unless authorised to do so by the **CFO**, or **CEO**, as appropriate.
- Approve any contract or transaction which **binds the Trust** to credit finance commitments without the clear written prior authority of the **CFO**. This includes all Executive and Care Group Directors of the Trust and all other **officers**.
- Order any goods or services, including agency staff, other than by using one of the Trust Approved Procurement Systems, unless previously authorised to do so by the **CFO**.
- Order goods or services **directly from suppliers**. Procurement will negotiate contracts which will provide catalogues of goods and services, from which orders may be raised. These instructions provide clear guidance on purchasing and contract tendering and these must be followed. In exceptional circumstances, where senior **officers** of the Trust wish to operate direct ordering procedures, the approval of the **CEO** and **CFO** must be obtained.
- Enter into contracts whereby the payment for the good or service is paid for in advance expect with the explicit agreement of the **CFO**.
- **Carryout unauthorised acts** that may result in the Trust incurring liabilities (directly or indirectly) or which may diminish the value of any of the Trust’s assets (including the Trust’s brand or reputation).

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5.2.3. The main points of the Schemes of Delegation approval limits are summarised below. This should be read in conjunction with the full tables detailed in Appendix 1

Capital Spend	
Capital projects not included in the Annual Capital Plan require business case approval	Once quotes are worked up, the case must be presented to the Business Case Group, following which it progressed through Executive Management Committee and Finance and Investment Committee to the Board of Directors. This is regardless of the source of funding requiring appropriate approval of business cases before submission to NHSE/ DHSC.
Budgets allocated as set out in the Annual Capital Plan are signed off by the Board of Directors. PO/ invoice approval limits are:	Monitored and reported through Capital Investment Group. Overall operational delivery rests with Operational Heads: <ul style="list-style-type: none"> <li>• Medical Equipment: Chief Medical Officer</li> <li>• Estates: Director of Estates &amp; Facilities</li> <li>• DDaT: Chief Digital Information Officer</li> </ul>
Up to £50,000	As by respective Operational Heads
Up to £250,000	Respective Operational Heads (as above)
Up to £1,500,000	Chief Finance Officer
Up to £2,499,999	Chief Executive
Above £2,500,000	Board of Directors

Revenue Spend – RBFT & HFMS – agreement of contracts (only once appropriate training has been received to the satisfaction of the CFO) and approval of POs/ invoices received (This does not include special payments)	
Up to £50,000	Budget holders, as determined by Care Group Directors, DoEF and Heads of Corporate Departments
Up to £250,000	Executive Directors (including Care Group Directors) with restricted powers of delegation, and HFMS directors for HFMS business
Up to £1,500,000	Chief Finance Officer
Up to £2,499,999	Chief Executive
Above £2,500,000	Board of Directors

Charity Spend	
Up to £1,000	Two Fund Advisors
Up to £10,000	Three Fund Advisors and Charity Director
Up to £50,000	All above and Care Group Manager/Matron and Charity Grants Panel
Up to £90,000	All above and Care Group Director or Executive Director and Charity Committee
Up to £1,500,000	All above and Chief Finance Officer
Up to £2,499,999	All above and Chief Executive
Above £2,500,000	All above and Board of Directors

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## Section Two – Detailed Guidance

### 1. Audit

#### 1.1. Internal Audit

1.1.1 The Chief Finance Officer is responsible for:

- a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control and efficient use of resources, including the establishment of an effective internal audit function;
- b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;
- c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
- d) ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee of the coverage and results of the work of the service. The report must cover:
  - a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
  - major internal financial control weaknesses discovered;
  - progress on the implementation of internal audit recommendations;
  - progress against plan over the previous year;
  - strategic audit plan covering the coming three years; and
  - a detailed plan for the coming year.

1.1.2 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

- a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- b) access at all reasonable times to any land, premises, members of the Board of Directors or employees of the Trust;
- c) the production of any cash, stores or other property of the Trust under the control of any member of the Board of Directors or an employee's control; and explanations concerning any matter under investigation.

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1.1.3 The Internal Audit service shall:

- a) provide an independent and objective opinion on risk management, control and governance arrangements by measuring and evaluating their effectiveness; and
- b) operate independently of the decisions made by the Trust and its employees; and of the activities which it audits. No member of the team providing the internal audit service will have executive responsibilities.

1.1.4 The Internal Audit will review, appraise and report upon:

- a) Establish and monitor the achievement of the Trust's strategic and operational objectives;
- b) Identify, assess and manage strategic and operational risks to achieving the organisation's objectives;
- c) Identify the extent of compliance with, and the financial effect of, the relevant established policies, plans and procedures;
- d) Identify the adequacy and application of financial and other related management Controls;
- e) Ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes;
- f) Identify the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
  - Fraud and other offences;
  - Waste, extravagance, inefficient administration;
  - Poor value for money or other causes; and
  - Any form of risk, especially business and financial risk but not exclusively so
- g) internal audit shall also independently verify the board assurance framework statements in accordance with guidance from the Department of Health and Social Care.

1.1.5 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

1.1.6 The Head of Internal Audit will provide an annual opinion on the effectiveness of the whole system of internal control.

1.1.7 The Head of Internal Audit will make suitable provision to form an opinion on key systems operated on behalf of other organisations, and key systems being operated by other organisations, either by deriving the opinions themselves or by relying on the opinions provided by other auditors/review bodies.

1.1.8 The Head of Internal Audit will normally attend Audit and Risk Assurance Committee meetings and has a right of access to all Audit and Risk Assurance Committee members, the Trust Chair and Chief Executive of the Trust.

1.1.9 The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit and Risk Assurance Committee and the Head of Internal Audit. The<sup>13</sup>

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agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

- 1.1.10 The designated officers must carry out agreed audit recommendations within the timescale for action agreed with the Head of Internal Audit. Failure to do so shall be reported to the Audit and Risk Assurance Committee and to the Chief Executive who shall take necessary action to ensure compliance with such recommendations.

## 1.2 Fraud and Corruption

- 1.2.1 In line with their responsibilities, the Trust Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the requirements included in the NHS Standard Contract on fraud and corruption (section 24), and with the requirements of the Bribery Act 2010 and other relevant legislation that has been or may be enacted.
- 1.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Counter Fraud Authority (NHSCFA).
- 1.2.3 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Standard Contract service conditions.
- 1.2.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.
- 1.2.5 The Trust's Chief Executive and Chief Finance Officer are responsible for ensuring access rights are given to NHS Counter Fraud Authority where necessary for the prevention detection and investigation of cases of fraud, bribery and corruption, in accordance with NHS Counter Fraud Authority standards for NHS Providers.

## 1.3 External Audit

- 1.3.1 The external auditor is appointed by the Council of Governors in accordance with the appointment process agreed by the Trust. The Audit and Risk Committee must ensure a cost-efficient service. Should there appear to be a problem then this should be raised with the external auditor and referred to the Audit and Risk Committee if it cannot be resolved.

# 2 Allocations, Business Planning, Budgets, Budgetary Control and Monitoring

## 2.1 Preparation and Approval of Business Plans and Budgets

- 2.1.1. The Chief Executive will compile and submit to the Board of Directors an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

- a) a statement of the significant assumptions on which the plan is based; and
- b) details of major changes in workload, delivery of services or resources required to<sup>14</sup>

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- achieve the plan; and
  - c) An assessment of risks and plans for their management.
- 2.1.2. Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board of Directors. Budgets will:
- a) be in accordance with the aims and objectives set out in the Trust’s business plan and its long-term financial strategy;
  - b) accord with financial and other targets, and with workforce and activity plans;
  - c) be produced following discussion with appropriate budget holders;
  - d) be prepared within the limits of available funds; and
  - e) identify potential risks.
- 2.1.3. The Chief Finance Officer shall monitor financial performance against budget and business plan, periodically review them, and report to the Board of Directors.
- 2.1.4. All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be compiled and financial performance against budgets to be monitored.
- 2.1.5. All budget holders will sign up to their allocated budgets at the commencement of each financial year.
- 2.1.6. All budget holders will provide information on a monthly basis to allow the Chief Finance Officer to compile forecast outturn.
- 2.1.7. Where likely adverse performance to budget is identified all budget holders must submit remedial plans to ensure that all income targets are achieved and expenditure plans do not exceed budget.
- 2.1.8. The Chief Finance Officer may implement further recovery actions and limit the delegated authority of budget holders where there is persistent adverse financial performance.
- 2.1.9. The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

**2.2. Budgetary Delegation**

- 2.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:
- a) the amount of the budget;
  - b) the purpose(s) of each budget heading;
  - c) individual and group responsibilities;
  - d) authority to exercise virement;

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- e) achievement of planned levels of service; and
- f) the provision of regular reports.

2.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Chief Finance Officer (see Appendix 1).

2.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

2.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

### 2.3 Budgetary Control and Reporting

2.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

- a) monthly financial reports to the Board of Directors in a form approved by the Board of Directors containing:
  - income and expenditure to date showing trends and forecast year-end position;
  - movements in working capital;
  - movements in cash and capital;
  - workforce spend and whole time equivalents (“WTEs”)
  - capital project spend and projected outturn against plan;
  - explanations of any material variances from plan; and
  - details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation.
- b) investigation and reporting of variances from financial and workforce budgets;
- c) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
- d) monitoring of management action to correct variances; and
- e) arrangements for the authorisation of budget transfers.

2.3.2 The Budgetary Control Policy outlines the requirements of key individuals who have budgetary responsibilities within the organisation. The policy includes details of delegated powers, the process for budget preparation, reporting procedures, virement of budgets to provide structure and support to both the Trust and budget holders.

2.3.3 Each budget holder is responsible for ensuring that:

- a) any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Board of Directors;
- b) the amount provided in the approved budget is not used in whole or in part for any

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purpose other than that specifically authorised subject to the rules of virement;

c) no permanent employees are appointed without confirmation that funding to support the appointments has been established through the Finance Department and authorised as such by the Chief Finance Officer or delegated officer.

d) they comply with the Trust's Budgetary Control Policy as devised by the Chief Finance Officer;

2.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual business plan.

## 2.4 Capital Expenditure

2.4.1. The general rules applying to delegation and reporting shall also apply to capital expenditure.

2.4.2. The annual capital plan is to be considered initially by Capital Programme Committee. CPC will receive options papers and details of proposed capital spending and will subsequently make recommendations to Finance and Investment Committee before seeking approval from the Board of Directors as part of the annual planning round.

2.4.3. Any capital expenditure approved as part of the agreed capital plan will be subject to in year authorisation and following of the mandatory procurement process. Officers are subject to the authorisation limits set out in Appendix 1 and the requirement for an approved business case as part of the authorisation process to ensure value for money, as set out by the Chief Finance Officer.

2.4.4. If there is a variation to the agreed capital plan, the Chief Finance Officer and Finance and Investment Committee must be notified. This does not include instances of reactive backlog works and replacement of redundant equipment where the required expenditure is in line with the overall backlog and equipment replacement programme.

## 3 Annual Accounts and Reports

3.1 The Chief Finance Officer, on behalf of the Trust, will:

3.1.1 prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

3.1.2 prepare and submit annual financial reports to the Department of Health and Social Care and NHS England in accordance with current guidelines; and

3.1.3 submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

3.2 The Trust's annual accounts must be audited by an external auditor appointed by the Council of Governors in accordance with the appointment process agreed with the <sup>17</sup>

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Trust, and in accordance with appropriate international auditing standards.

- 3.3 The Trust's audited annual accounts must be presented to a public meeting and made available to the public.
- 3.4 The Trust will publish an annual report, in accordance with national guidelines on local accountability, and present it at a public meeting.
- 3.5 The document will comply with the Department of Health and Social Care's Group Accounting Manual.

## **4 Bank Accounts**

### **4.1 General**

4.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and Directions issued by the Department of Health and Social Care.

4.1.2 The Board of Directors shall approve the banking arrangements.

### **4.2 Bank and Government Banking Service (GBS) Accounts**

4.2.1 The Chief Finance Officer is responsible for:

- a) bank accounts and GBS accounts;
- b) establishing separate bank accounts for the Trust's non-exchequer funds, including charitable funds;
- c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
- d) reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn;
- e) monitoring compliance with Department of Health and Social Care guidance on the level of cleared funds; and
- f) ensuring covenants attached to bank borrowing are adhered to.

### **4.3 Banking Procedures**

4.3.1 The Chief Finance Officer will prepare detailed instructions, on the operation of all Trust bank accounts that must include:

- a) the conditions under which each bank and GBS account is to be operated, including the overdraft limit if applicable;
- b) those authorised to approve payments, bank transfers, sign cheques or other orders drawn on the Trust's accounts.

4.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

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- 4.3.3 It is the responsibility of the Chief Finance Officer to monitor the banking arrangements to ensure best value for money is obtained.
- 4.3.4 The Chief Finance Officer should monitor authorisation levels and check signatories to ensure thresholds and individuals meet with the ongoing needs of the Trust.
- 4.3.5 The Chief Finance Officer will report to the Audit and Risk Committee of any changes to the Trust's bank accounts including the opening/ closing of accounts and changes in signatory panel.

**4.4 Tendering and Review**

- 4.4.1 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they continue to reflect best value for money.
- 4.4.2 This review is not necessary for GBS accounts.
- 4.4.3 Competitive tenders should be sought at least every five years. The Chief Finance Officer shall report to the Board of Directors the reason(s) for continuing existing banking arrangements for longer than five years, without competitive review.
- 4.4.4 The Chief Finance Officer shall report the results of any tendering exercise to the Board of Directors.

**4.5 External Borrowing**

- 4.5.1 The Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay dividend on and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Chief Finance Officer is also responsible for reporting periodically to the Board of Directors concerning the PDC debt and all loans and overdrafts.
- 4.5.2 The Board of Directors shall agree the list of employees authorised to make short term borrowings on behalf of the Trust. This shall include the Chief Executive and the Chief Finance Officer.
- 4.5.3 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.
- 4.5.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money and comply with the latest guidance from the Department of Health and Social Care. Any short-term borrowing required must be authorised by the Chief Finance Officer.

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## 5 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

### 5.1 Income Systems

- 5.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.
- 5.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

### 5.2 Fees and Charges

- 5.2.1 The Trust shall follow the Department of Health and Social Care's advice in setting prices for service agreements.
- 5.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.
- 5.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions in order to facilitate the timely raising of invoices and collection of debt.

### 5.3 Debt Recovery

- 5.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.
- 5.3.2 Income not received should be dealt with in accordance with losses procedures.
- 5.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

### 5.4 Security of Cash, Cheques and Other Negotiable Instruments

- 5.4.1 The Chief Finance Officer is responsible for:
- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
  - ordering and securely controlling any such stationery;
  - the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
  - prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

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- 5.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.
- 5.4.3 All cheques, postal orders, payable orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.
- 5.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.
- 5.4.5 Under no circumstances will the Trust accept cash payments of £10,000 (or equivalent in any currency) in respect of any single transaction or series of transactions which appear to be linked (in line with HM Revenue and Customs guidance on “Money laundering supervision for high value dealers”). Any attempts by an individual to effect payment above this amount should be notified immediately to the Chief Finance Officer.

## 6 NHS Service Agreements for the Provision of Services

- 6.1 The Board of Directors will approve standard terms and conditions for legally binding contracts, on the basis of which the Trust will provide healthcare services.
- 6.2 Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation. The CEO is responsible for negotiating contracts for the provision of services to patients in accordance with the budget.
- 6.3 In carrying out these functions, the CEO should take into account the advice of the CFO regarding costing, pricing of services, payment terms and conditions of service agreements. Contracts should be as devised as to achieve activity and performance targets, minimise risk, and to maximise the Trust's opportunity to generate income where appropriate.
- 6.4 The Trust will produce a reference cost tariff in accordance with NHS guidelines. The Trust will comply with the Department of Health and Social Care Guidance on setting prices for the provision of NHS healthcare (i.e. NHS Payment Scheme) as far as this allows. Other prices and tariffs must be approved by the CFO.
- 6.5 The CFO shall ensure that a summary of the Trust's contract income is reported annually to the Board of Directors. The CFO shall also produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income. Any pricing of contracts at marginal cost should be undertaken by the CFO in accordance with a policy and tariff reported to the Board of Directors.

## 7 Terms of Service, Allowances and Payment of Members of the Board of Directors and Executive Committee and Employees

### 7.1 Remuneration and Terms of Service

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7.1.1 In accordance with Standing Orders the Board of Directors shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting (see also Standing Order 5.8).

7.1.2 The Committee's role is outlined within the Scheme of Delegation and Reservation and within its agreed terms of reference.

## 7.2 Funded Establishment

7.2.1 The workforce plans incorporated within the annual budget will form the funded establishment. Changes to the funded establishment require the authorisation of the Director of Finance or delegated officer.

7.2.2 The funded establishment of any department may not be varied in any way which causes expenditure to exceed the authorised annual budget without the approval of the Director of Finance.

## 7.3 Staff Appointments

7.3.1 No officer or member of the Board of Directors may engage, re-engage or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any respect of remuneration unless:

- a) they have delegated authority in accordance with the Scheme of Delegation;
- b) the change is in accordance with Trust policies;
- c) the appointment is within the limit of their approved budget and funded establishment; and
- d) they are exercising economy and efficiency in the use of human resources.

7.3.2 Where changes do not comply with the above, authorisation must be gained from the Chief Executive before committing to any change.

7.3.3 It is the budget holder's responsibility to ensure the Finance Department are made aware of any such changes to their approved budget to enable the transaction of a budget variation.

7.3.4 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc. for employees.

## 7.4 Processing Payroll

7.4.1 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.4.2 The Chief Finance Officer is responsible for:

- a) specifying timetables for submission of properly authorised time records, expense claims and other notifications;

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- b) the final determination of pay and allowances;
- c) making payment on agreed dates; and
- d) agreeing method of payment.

7.4.3 The Chief Finance Officer will issue instructions regarding:

- a) verification and documentation of data;
- b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
- c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- d) security and confidentiality of payroll information;
- e) checks to be applied to completed payroll before and after payment;
- f) authority to release payroll data under the provisions of the Data Protection Act and General Data Protection Regulation (GDPR);
- g) methods of payment available to various categories of employee and officers;
- h) procedures for payment by cheque, bank credit including BACS, or cash to employees and officers;
- i) procedures for the recall of cheques and bank credits including BACS;
- j) pay advances and their recovery;
- k) maintenance of regular and independent reconciliation of pay control accounts;
- l) separation of duties of preparing records and handling cash; and
- j) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

7.4.4 Appropriately nominated managers have delegated responsibility for:

- a) submitting time records, travel, subsistence and removal expense claims and other notifications in accordance with agreed timetables;
- b) completing and authorising time records, travel, subsistence and removal expense claims and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and
- c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

## 7.5 Salary Advances, Overpayment and Recovery

7.5.1 Trust employees are expected to be truthful and honest in relation to salary overpayment and repayment;

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- 7.5.2 Salary advances will only be considered for amounts above £100;
- 7.5.3 When salary overpayments occur, the Trust will pursue repayment in accordance with its Overpayments Recovery Policy.

**7.6 Salary Sacrifice**

- 7.6.1 The salary sacrifice schemes are subject to the applicable policies which provide detailed guidance.

**7.7 Employee Expenses**

**7.7.1 Amount Paid**

The Chief Finance Officer shall be responsible for determining the correct payment of claims for travelling and other expenses, including deduction of amounts liable to the Inland Revenue under the appropriate regulations. The Chief Finance Officer will not be liable to pay such claims where, in their opinion, it has not been possible for the certifying manager to verify the accuracy of the data.

**7.7.2 Certification of Claims**

Certification of claims by, or on behalf of, the budget holder shall be taken to mean that the certification officer is satisfied that the journeys made were authorised, that expenses claimed were properly and necessarily incurred, and that allowances are properly payable by the Trust. The employee will upload any receipts onto the electronic expenses system which the certifying manager will examine before certification. All original receipts will be kept by the employee or the certifying manager.

**7.7.3 Date of Claim**

Eligible employee’s authorised claims for reimbursement of expenses shall be done electronically. Where appropriate, completed and authorised claims shall be submitted to the Chief Finance Officer on a regular basis, in accordance with an agreed timetable and as soon as practical after the expense has been incurred. Claims for reimbursement of expenses, which relate to a period or date more than three months (unless otherwise stated within an approved policy) previous to the date of receipt of the claim form by the Chief Finance Officer, shall be accompanied by a letter detailing the reasons for such delay. Expense claims that are more than nine months previous to the date of receipt of the claim form by the Chief Finance Officer, shall, subject to the discretion of the Chief Finance Officer, not be paid.

**7.8 Contracts of Employment**

- 7.8.1 The Board of Directors shall delegate responsibility to an officer for:
  - a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and
  - b) dealing with variations to, or termination of, contracts of employment.

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## 7.9 Agency, Self-Employed or Third-Party Workers Including Contract for Services

- 7.9.1 Where exceptional circumstances exist within a department e.g. high levels of escalation and acuity, self-employed workers or workers supplied via a third party are to be retained, then:
- a) the contract may only be entered into by a budget holder having sufficient resources within the limit of their budget or who is authorised for that purpose by the Chief Executive or his delegated officer; and
  - b) the Chief Finance Officer shall be consulted and must give authorisation if the contractor is not on framework/the current list of authorised suppliers;
- 7.9.2 Where there is not sufficient resource within the approved budget permission must be sought prior to an increase in temporary staffing levels through the appropriate director/director on-call.
- 7.9.3 It is the responsibility of the budget holder at the earliest opportunity to review staffing levels to ensure value for money is obtained and funding is both identified and approved to cover the increased cost.
- 7.9.4 The Chief People Officer shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors. These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, known as Intermediaries Legislation, or "IR 35".
- 7.9.5 All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

## 7.10 Changes to Bank/Internal Locum Rates

- 7.10.1 the Chief Finance Officer will oversee the process of agreeing bank/locum rates of payment within the Trust for all staff;
- 7.10.2 this process will be documented and communicated throughout the Trust;
- 7.10.3 any proposals (short-term or long-term) to operate outside of this process will require Finance involvement with the approval limits in Appendix A setting out the level of authorisation required;
- 7.10.4 when there are other fees involved in addition to the hourly rate (e.g. engagement fees), these need to be approved by the respective budget holder prior to appointment. The budget holder must ensure that budget has been clearly identified to cover the cost of the fees prior to appointment;
- 7.10.5 the Trust's temporary staffing functions (medical and non-medical) will oversee the operationalisation and exception reporting of the process.

## 7.11 Approving External Agency Rates

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- 7.11.1 the Chief Finance Officer will oversee the process of agreeing the financial parameters for the engagement of agency staff within the Trust ensuring compliance with latest NHS England's agency rules (using the available price card as a reference);
- 7.11.2 this process will be documented and communicated throughout the Trust;
- 7.11.3 the process will include an escalation process should the potential rates being negotiated exceed the Trust's agreed parameters; and
- 7.11.4 the Trust's temporary staffing functions (medical and non-medical) will oversee the operationalisation and exception reporting of the process.

## 8 Non-Pay Expenditure

### 8.1 Delegation of Authority

- 8.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.
- 8.1.2 The Chief Finance Officer will set out:
  - a) the list of managers who are authorised to place requisitions for the supply of goods and services; and
  - b) the maximum level of each requisition and the system for authorisation above that level.
- 8.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services and this shall be followed when entering into any agreement. Contract terms and conditions used in contract shall only be those approved by the Trust.

### 8.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

- 8.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply will be sought, prior to commitment. In order to commit expenditure, the requisitioner must follow the Trust's standard procurement process. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer and/or the Chief Executive shall be consulted.
- 8.2.2 The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.
- 8.2.3 The Chief Finance Officer will:
  - a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and regularly reviewed;

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- b) prepare procedural instructions or guidance, where not already provided in the Scheme of Delegation or procedure notes for budget holders, on the obtaining of goods, works and services incorporating the thresholds;
- c) be responsible for the prompt payment of all properly authorised accounts and claims;
- d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
  - A list of Board of Directors members/employees (including specimens of their signatures) authorised to certify invoices.
  - Certification that:
    - i) goods have been duly received, examined and are in accordance with specification and the prices are correct;
    - ii) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
    - iii) in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
    - iv) where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
    - v) the account is arithmetically correct; and
    - vi) the account is in order for payment.
  - A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
  - Instructions to employees regarding the handling and payment of accounts within the Finance Department.
- e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in paragraph 9.2.4.
- f) The Chief Finance Officer is responsible for ensuring, as far as possible, payments are made in accordance with the Better Payment Practice Code.

#### 8.2.4 Prepayments

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- a) Prepayments are only permitted where exceptional circumstances apply. In such instances prepayments are only permitted where normally it would be expected that the financial advantages outweigh the disadvantages ;
- b) the appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
- c) the Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contract Regulations where the contract is above a stipulated financial threshold) and in all circumstances the Director of Finance should approve all prepayments; and
- d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

8.2.5 Official Orders must:

- a) be consecutively numbered;
- b) be in a form approved by the Chief Finance Officer;
- c) state the Trust's terms and conditions of trade including the need for suppliers to quote a valid order number when submitting invoices for payment; and
- d) only be issued to, and used by, those duly authorised by the Chief Executive. Lists of authorised officers shall be maintained and a copy of each list supplied to the Chief Finance Officer; and
- e) be authorised, prior to being issued, according to the Trust's Scheme of Delegation.

8.2.6 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

- a) all contracts (except as otherwise provided for in the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
- b) contracts above specified thresholds are advertised and awarded in accordance with The Procurement Act 2023 or Provider Selection Regime as applicable;
- c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care and NHS England.

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- d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
  - o isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
  - o conventional hospitality, such as lunches in the course of working visits;
- e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;
- f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash or on purchase cards;
- g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
- h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
- i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
- j) changes to the list of directors/employees and officers authorised to certify invoices are notified to the Chief Finance Officer;
- k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer; and
- l) petty cash records are maintained in a form as determined by the Chief Finance Officer.

8.2.7 The Chief Executive and Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within NHS Estates guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

8.2.8 Should a tender be required the process adopted is stipulated in these Standing Financial Instructions.

### 8.3 Ensuring Segregation of Duties

8.3.1 Officers must ensure that effective segregation of duties are maintained throughout the procurement process. This means that the same officer cannot both requisition and approve the procurement of any goods, services or works. This applies to transactions undertaken via purchase orders or on a non-purchase order basis.

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## **8.4 Joint Finance Arrangements with Local Authorities and Voluntary Bodies**

8.4.1 Payments to local authorities and voluntary organisations made under the powers of section 75 and section 256 of the NHS Act 2006 (as amended) shall comply with procedures laid down by the Director of Finance which shall be in accordance with this Act (see also Standing Order 11.5).

## **8.5 Use of Trust Corporate Credit Card**

8.5.1 Corporate credit cards are only for use in situations where it is not possible to purchase goods or service via eproc (Purchase Order).

8.5.2 Procurement must be consulted prior to a transaction taking place to determine if there is no other alternative purchase options.

8.5.3 Employees allocated a corporate credit card must not permit any other individual to use the card or to give the card to any other individual and must not give any other individual the details of the card i.e. card number, pin number or security number.

8.5.4 Employees making purchases by corporate credit card must retain all receipts including receipts from on-line purchases.

8.5.5 Monthly statements will be issued by the credit card company to those employees with cards allocated to them. Upon arrival of the statement, the receipts for the transactions on the statement must be attached to it. Against each line on the statement must be written the cost centre and subjective/account code or PO number to which the transactions should be coded.

8.5.6 It is the employee's responsibility to advise the Trust Treasury team of any transactions on a statement that are not recognisable for investigating.

# **9 Capital Investment, Managed Service Contracts, Private Financing, Fixed Asset Registers and Security of Assets**

## **9.1 Capital Investment Including Managed Service Contracts**

9.1.1 The Chief Executive Officer:

- a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
- c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

9.1.2 For every capital expenditure proposal, including the potential to purchase the asset through a managed service contract the Chief Executive shall ensure:

- a) that a business case (in line with the guidance contained within the current Department of Health and Social Care's guidance), is produced setting out: 30

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- an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
  - appropriate project management and control arrangements; and
  - the involvement of appropriate Trust personnel and external agencies;
- b) that the Chief Finance Officer has certified professionally to the costs and revenue consequences detailed in the business case. For a managed service contract this includes whether it is an operating or finance lease and impact on the Trust's Capital Departmental Expenditure Limit (CDEL) and VAT liability. The certification may be derived through external expert advice.
- c) Where the sum involved exceeds delegated limits, the business case must be referred to NHS England and/or the Department of Health and Social Care in line with current guidelines.
- 9.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of NHS Estates guidance.
- 9.1.4 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.
- 9.1.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
- 9.1.6 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.
- 9.1.7 The Chief Executive, shall issue to the manager responsible for any capital scheme:
- a) specific authority to commit expenditure;
  - b) authority to proceed to tender; and
  - c) approval to accept a successful tender.
- 9.1.8 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with NHS Estates guidance and the Trust's Standing Orders. The appropriate signatories shall be governed by the authorisation levels set out in Appendix A.
- 9.1.9 The Chief Finance Officer shall issue procedures governing financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes as notified by the Department of Health and Social Care.

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## 9.2 Private Finance

9.2.1 The Trust should normally test for private finance when considering a capital procurement. When the Trust proposes to use finance that is to be provided other than through its Allocations, the following procedures shall apply:

- a) the Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;
- b) the proposal must be specifically agreed by the Board of Directors; and
- c) where the sum involved exceeds delegated limits, the business case must be referred to the appropriate Directorate of the Department of Health and Social Care and/or treated as per current guidelines.

## 9.3 Leases (Finance and Operating)

9.3.1 Where it is proposed that leasing (either operating or finance) shall be considered in preference to capital procurement then the following should apply:

- a) The selection of a contract/finance company shall be on the basis of competitive tendering and quotations sought via the procurement department;
- b) all proposals to enter into a leasing agreement shall be referred to the Chief Finance Officer before acceptance of any offer;
- c) the Chief Finance Officer shall ensure that the proposal demonstrates best value for money; and
- d) the proposal shall be agreed in writing by the Chief Finance Officer prior to acceptance of any offer to the lease.

## 9.4 Asset Registers

9.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

9.4.2 The Trust shall maintain an up-to-date asset register recording fixed assets. The asset register shall be verified annually.

9.4.3 The minimum data set to be held within the asset registers shall be as specified in the Group Accounting Manual as issued by the Department of Health and Social Care.

9.4.4 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

- a) properly authorised and approved agreements, architect certificates, supplier invoices and other documentary evidence in respect of purchases from third<sup>32</sup>

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- parties;
  - b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and
  - c) lease agreements in respect of assets held under a finance lease and capitalised.
- 9.4.5 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).
- 9.4.6 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
- 9.4.7 The Chief Finance Officer shall ensure that appropriate accounting policies are adopted to ensure appropriate ongoing valuation of all assets.
- 9.4.8 The value of each asset shall be valued in according with a modern equivalent assets valuation in accordance with methods specified by the Department of Health and Social Care.
- 9.4.9 The value of each asset shall be depreciated using methods and rates in line with guidance specified by the Department of Health and Social Care.
- 9.4.10 The Chief Finance Officer of the Trust shall calculate and pay capital charges as specified in the NHS Group Accounting Manual issued by the Department of Health and Social Care.

## 9.5 Security of Assets

- 9.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.
- 9.5.2 Asset control procedures (including fixed assets, inventories, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:
- a) recording managerial responsibility for each asset by reference to its location;
  - b) identification of additions and disposals;
  - c) identification of all repairs and maintenance expenses;
  - d) physical security of assets;
  - e) periodic verification of the existence of, condition of, and title to, assets recorded; and
  - f) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.
- 9.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

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- 9.5.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board of Directors members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with agreed procedures.
- 9.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board of Directors members and employees in accordance with the procedure for reporting losses.
- 9.5.6 Where practical, assets should be marked as Trust property. Particular care should be taken to safeguard valuable portable items such as laptops, desktops and mobile phones.

## 10 Tendering and Contracting Procedure

### 10.1 Duty to comply with Standing Financial Instructions

- 10.1.1 The procedure for making a contract by or on behalf of the Trust shall comply with these Standing Financial Instructions.

### 10.2 Procurement Regulations

- 10.2.1 The Procurement Act 2023 or Provider Selection Regime, prescribe procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Financial Instructions.
- 10.2.2 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care, NHS England and Estate code (estates guidance) in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS" and guidance from NHS England and NHS Improvement.

### 10.3 Advertised Competitive Procurement

- 10.3.1 The Trust shall ensure that advertised competitive contract award processes, that are based on objective, relevant and proportionate criteria are undertaken for the supply of goods and services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health and Social Care); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

### 10.4 Commissioning of Healthcare Services

- 10.4.1 The Trust shall follow the requirements of the Provider Selection Regime and ensure that competitive procurement is undertaken as per the threshold detailed in Appendix 1. The Provider Selection Regime applies to all Healthcare Contracts regardless of value.

### 10.5 Joint Purchasing

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10.5.1 A single approach to tender and quotation for competitive procurement limits should apply to all contracts which are to be placed for goods and services that are required for more than one Trust. In such instances the limits are defined in Appendix 1 to these SFIs. Any deviation from these limits should be agreed in advance with Audit and Risk Committee.

**10.6 Exceptions and instances where formal procurement procedures need not be applied**

10.6.1 Formal tendering procedures **need not be applied** where:

a) the estimated total expenditure does not, or is not reasonably expected to exceed the level set in the Scheme of Delegation; it is a breach of SFIs to split contracts to avoid thresholds; and

b) where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care or its agencies, in which event the said special arrangements must be complied with.

10.6.2 Competitive procurement procedures **may be waived** in the following circumstances:

a) The waiving of competitive tendering procedures should not be used to:

- avoid competition, or
- avoid public procurement legislation/FTS (Find a Tender Service), or
- for the administrative convenience, or
- award further work originally appointed through a competitive procedure.

b) in very exceptional circumstances where the Chief Executive or Chief Finance Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

c) Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.

d) where contracts have been awarded for the benefit of Public Sector Bodies, to which the Trust is entitled to access (e.g. Framework Contracts);

e) where a national or regional purchasing consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

f) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

g) where specialist expertise is required and is available from only one source;

h) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the<sup>35</sup>

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new task would be inappropriate;

- i) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; and
- j) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

10.6.3 Where it is decided that competitive quotes or tendering is not applicable and should be waived, a non-competitive quotation in writing will be obtained using the appropriate terms and condition of contract, unless procuring via a Direct Award Framework Agreement; and the fact of the waiver should be documented with reasons on a **Competitive Waiver** form obtained via the Procurement Department.

10.6.4 A competitive quotation is not required if procuring via a Direct Award Framework Agreement, the Framework Agreement instructions must be fully complied with.

10.6.5 In accordance with the Scheme of Delegation, all waivers, with the exception of those for pharmaceuticals, must be signed off by the Chief Finance Officer or their deputy, prior to authorisation.

10.6.6 Full breach waivers must be jointly signed off by the Chief Finance Officer and the Chief Executive Officer where the value thereof exceeds £500k.

10.6.7 The Trust position is to strive for zero Full Breach Waivers, and when required must only be used in exceptional circumstances, noting that it may be a breach of Procurement Legislation thereby exposing the trust to a risk of legal challenge.

10.6.8 Waivers must be reported to the Audit and Risk Committee.

10.7 The Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, as far as practicable having regard to their capacity to supply the goods or materials or to undertake the services or works required.

## 10.8 Invitation to Tender

### 10.8.1 Paper based or electronic tenders

The tendering process may be paper based or using an electronic tendering system. For tenders managed by the Procurement department, they use a fully audited electronic sealed bid process, where quotations and tenders cannot be opened until the set date and time. There is a complete electronic audit trail built into this process.

The following paragraphs indicate where the tendering process is different between paper and electronic.

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- a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.
- b) For paper tenders, all invitations to tender shall state that no tender will be accepted unless:
  - submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager; and
  - that tender envelopes/packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.
- c) For electronic tenders, the invitation shall state that only tenders submitted electronically will be considered.
- d) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.
- e) Every tender for building and engineering works shall reflect Department of Health and Social Care Estates Technical Guidance and, except any tender for maintenance work only, shall embody or be in the terms issued by either the Joint Contracts tribunal (JCT) Standard Forms of Building Contract, or for major projects, the appropriate New Engineering Contract (NEC) form of contract shall be used. Where appropriate, a Model Form of Engineering Contract should be used when the content of the work is primarily engineering. Procurement of professional services for the delivery of works should also be made using the form of professional services contract appropriate to the construction works being undertaken.

**10.8.2 Receipt and safe custody of tenders**

- a) For paper tenders, the Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be endorsed on the tender envelope/package.
- b) For electronic tenders, the tenders are locked automatically until the published date and time of opening. The date and time of receipt of each tender is stored electronically.

**10.8.3 Opening tenders and Register of tenders (paper tenders)**

- a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.
- b) The 'originating' department will be taken to mean the department sponsoring or commissioning the tender.
- c) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Chief Finance Officer or any approved Senior<sup>37</sup>

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Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

- d) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.
- e) The Trust's Company Secretary will count as a Director for the purposes of opening tenders.
- f) Every tender received shall be marked with the date of opening and initialed by those present at the opening.
- g) A register shall be maintained by the Chief Executive, or a person authorised by him/her, to show for each set of competitive tender invitations dispatched:
  - the name of all firms individuals invited;
  - the names of firms' individuals from which tenders have been received;
  - the date and time the tenders were opened;
  - the persons present at the opening;
  - the price shown on each tender; and
  - a note where price alterations have been made on the tender.
- h) Each entry to this register shall be signed by those present. A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.
- i) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

**10.8.4 Opening tenders and Register of tenders (electronic tenders)**

- a) Because the Procurement department uses a fully audited electronic sealed bid process, where quotations and tenders cannot be opened until the set date and time, there is a complete electronic audit trail of viewing, opening dates, times, responses and amendments, automatically built into the process.
- b) After the closing date the tender documents are available electronically to see. Only the Procurement department have this access.

**10.8.5 Admissibility**

- a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.
- b) Where only one tender is sought and/or received, the Chief Executive and

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Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

#### 10.8.6 Late tenders

- a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.
- b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.
- c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

#### 10.8.7 Acceptance of formal tenders

- a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.
- b) The most advantageous tender shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.
- c) It is accepted that for professional services such as management consultancy, the most advantageous price does not always represent the best value for money. Other factors affecting the success of a project include:
  - experience and qualifications of team members;
  - understanding of client's needs;
  - feasibility and credibility of proposed approach; and
  - ability to complete the project on time.
- d) Where other factors are taken into account in selecting a tenderer, for example, Social Value, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the most advantageous tender clearly stated.
- e) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust, and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

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- f) The use of these procedures must demonstrate that the award of the contract was:
- not in excess of the going market rate/price current at the time the contract was awarded; and
  - that best value for money was achieved.
- g) All tenders should be treated as confidential and should be retained for inspection.

## **10.9 Quotations: Competitive and Non-Competitive**

### **10.9.1 General Position on Quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds the tendering limits set out in Appendix B.

### **10.10 Competitive Quotations**

- a) Quotations should be obtained from at least 3 firms/individuals as far as practicable, based on specifications or terms of reference prepared by, or on behalf of, the Trust.
- b) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
- c) All quotations should be treated as confidential and should be retained for inspection.
- d) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the most advantageous, then the choice made and the reasons why should be recorded in a permanent record.

### **10.11 Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

- a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;
- b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;
- c) miscellaneous services, supplies and disposals;

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- d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this paragraph apply.
- e) to support a waiver in ensuring compliance with NHS Terms and Conditions of Contract

**10.12 Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance (within their delegated limits).

**10.13 Authorisation of Tenders and Competitive Quotations**

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by officers of the Trust provided this is within their delegated limits.

Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

**10.14 Instances where formal competitive tendering or competitive quotation is not required**

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

- (a) the Trust shall use NHS Supply Chain, or other accredited direct award frameworks for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.
- (b) if the Trust does not use the NHS Supply Chain, or other accredited Framework Agreements the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

**10.15 Private Finance**

The Trust should normally test for private finance when considering a capital procurement. When the Trust proposes, or is required, to use finance provided by the private sector the following should apply:

- (a) the Chief Finance Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;
- (b) where the sum exceeds delegated limits, a business case must be referred to the appropriate Directorate of the Department of Health and Social Care for approval and/or treated as per current guidelines.

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- (c) the proposal must be specifically agreed by the Board of Directors; and
- (d) the selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

**10.16 Contracts**

The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State for Health and Social Care and shall comply with:

- (a) the Trust's Standing Orders;
- (b) the Trust's Standing Financial Instructions;
- (c) The Procurement Act 2023, Provider Selection Regime and other statutory provisions;
- (d) any relevant directions including: the NHS England Capital regime, investment and property business case approval guidance for NHS Providers; Group Accounting Manual; Estate code; and guidance on the Procurement of Management Consultants (*this is not an exhaustive list*); and
- (e) such of the NHS Standard Contract Conditions as are applicable.

10.17 Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

10.18 Every contract for building and engineering works which exceeds the limit set out in Appendix B shall be executed under the Common Seal of the Trust and should be embodied in a formal contract document which shall conform to the Standing Orders, NHS construction guidance, Procurement Regulations and other statutory provisions. This formal contract document should reflect any change in the terms and conditions of contract agreed following receipt of tenders. An official order for every contract resulting from an invitation to tender shall be issued for all building and engineering works.

10.19 In all contracts made by the Trust, the Board of Directors shall endeavor to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

**10.20 Personnel and Agency or Temporary Staff Contracts**

- a) The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts via framework/the current list of approved suppliers.

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- b) The Chief Finance Officer shall be consulted and must give authorisation if the contractor is not on framework/the current list of authorised suppliers.

**10.21 Healthcare Services Agreements**

- a) Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the relevant NHS guidelines. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefit Corporation, is a legal document and is enforceable in law.
- b) NHS to NHS Arrangements are not exempt under the Procurement Act 2023 or Provider Selection Regime and the legislation should therefore be considered before entering into any agreements.
- c) The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors.

**10.22 Cancellation of Contracts**

Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the NHS and in accordance with Standing Orders 9.2 and 9.3, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favor or disfavor to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him/her or acting on his behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on their behalf shall have committed any offence under the Bribery Act 2010 and other appropriate legislation.

**10.23 Determination of Contracts for Failure to Deliver Goods or Material**

There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

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## 10.24 Contracts involving Funds Held on Trust

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's funds and private resources.

## 11 Stores and Receipt of Goods

### 11.1 General Position

- 11.1.1 stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:
- 11.1.2 kept to a minimum;
- 11.1.3 subjected to annual stock take; and
- 11.1.4 valued at the lower of cost and net realisable value.

### 11.2 Control of Stores, Stocktaking, Condemnations and Disposal

- 11.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any pharmaceutical stocks shall be the responsibility of the Chief Pharmacist; the control of any fuel oil and coal of the Head of Estates.
- 11.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.
- 11.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores, including records for receipt of goods, issues, and returns to stores, and losses.
- 11.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.
- 11.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.
- 11.2.6 The designated manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also section 13). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

### 11.3 Goods Supplied by NHS Supply Chain

For goods supplied via the warehouses and Regional Distribution Centres of Supply Chain Coordination Limited (the management function of the NHS Supply Chain), the Chief Executive shall identify those authorised to requisition<sup>44</sup>

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and accept goods from the store. The authorised person shall check receipt against the delivery note who shall satisfy him/herself that the goods have been received.

## 12 Disposals and Condemnations, Losses and Special Payments

### 12.1 Disposals and Condemnations

12.1.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

12.1.2 When it is decided to dispose of a Trust asset, the policy for the management and/or disposal of assets must be adhered to. If required the head of department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

12.1.3 The appropriate signatories shall be governed by the authorisation levels set out in Appendix 1.

12.1.4 If the Trust wishes to sell land it shall follow agreed Government procedures for the disposal of surplus public land.

12.1.5 All unserviceable articles shall be:

- a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;
- b) recorded by the Condemning Officer in a form approved by the Chief Finance Officer that will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

12.1.6 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

12.1.7 Competitive tendering or quotation procedures shall not apply to the disposal of:

- a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;
- b) obsolete or condemned articles and stores, which may be disposed of in accordance with the policy for the management and/or disposal of assets;
- c) items to be disposed of with a collective estimated sale value of less than £10,000, this figure to be reviewed annually;
- d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and

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- e) land or buildings concerning which Department of Health and Social Care guidance has been issued but subject to compliance with such guidance.

## 12.1 Losses and Special Payments

- 12.1.1 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments including bad debt write-offs. The definition of losses and special payments can be found within the Group Accounting Manual.
- 12.1.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive Officer and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Chief Finance Officer must inform the relevant Local Counter Fraud Specialist.
- 12.1.3 The Chief Finance Officer must notify the Local Counter Fraud Specialist and external audit of all frauds.
- 12.1.4 The review of bad debt write offs must be carried out quarterly and any accounts selected for write off must be presented to the Chief Finance Officer or their deputy for authorisation. The account can then be processed as a bad debt via the ledger and be removed. All write-offs are recorded in the Trust's losses and special payments register.
- 12.1.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:
  - a) the Board of Directors, and
  - b) the External Auditor.
- 12.1.6 Within limits delegated to it by the Department of Health and Social Care, the Audit and Risk Committee shall approve the writing-off of losses.
- 12.1.7 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
- 12.1.8 For any loss, the Chief Finance Officer should consider whether any insurance claim could be made.
- 12.1.9 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.
- 12.1.10 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.
- 12.1.11 All special payments must be reported to the Audit and Risk Committee at regular intervals.

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### 13. Patients' Property

- 13.1. The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.
- 13.2. The **CEO** shall be responsible for ensuring patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into the Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.
- 13.3. The **CEO** shall require the **CFO**, in conjunction with the Care Group Directors, to provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property for all staff whose duty it is to administer the property of patients. Patient property must be recorded on the EPR (Electronic Patient Record) System under:

Assessment/Fluid Balance/Adult Systems Assessment/Patient Property/property Review Stage

### 14. Hospitality

- 14.1 The CEO shall be responsible for maintaining comprehensive records of all offers of hospitality, both accepted and rejected. The record shall be in a form designed by the CFO and completed records shall be available for inspection by the designated auditors or CFO, at all reasonable times.

### 15. Investments

- 15.1. Temporary cash surpluses must only be held as authorised by the Department of Health and Social Care and authorised by the Board of Directors.
- 15.2. The Chief Finance Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.
- 15.3. The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

### 16. Retention of documents

- 16.1. The CEO shall be responsible for maintaining archives for all documents required to be retained under the direction contained in the Records Management Code of Practice for Health and Social Care (the Code, available at <https://transform.england.nhs.uk/information-governance/guidance/records-management-code/records-management-code-of-practice/> ).
- 16.2. A summary of the retention periods for key documents and records will be produced. A copy of the document will be available to all members of staff.
- 16.3. The documents held in archives shall be capable of retrieval by authorised persons. 47

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- 16.4. Documents held under the Code shall only be destroyed at the express instigation of the CEO; records shall be maintained of documents so destroyed. The CFO shall provide advice on the retention of financial records.
- 16.5. The Chief Finance Officer shall provide advice on the retention of financial records.

## 17. Taxation & Excise Duties

- 17.1. The Chief Finance Officer shall ensure that the Trust’s liabilities of taxation and excise duty is managed appropriately, taking full account of available concessions, through maintenance of appropriate records, the preparation and submission of required returns and recovery of deductions at source.

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## Appendix 1:

### Scheme of delegation of powers from the Board of Directors to Officers of the Trust

1.0	Capital & asset purchases (including capital funded via lease finance or charitable grants)	Delegation arrangements	Additional information
1.1	Approval of the overall Trust Capital Budget and any in-year variations	Board of Directors	
1.2	Approval of overall budget allocation to individual capital projects and monitoring	Capital Programme Committee (CEO, CFO, CGDs, MD, DoN, DoEF)	Monthly report to Board of Directors
1.3	Approval of individual capital projects within the overall Capital Budget (including approval of variations)  Up to £1,500,000 Up to £2,499,999 Over £2,500,000	Chief Finance Officer Chief Executive Officer Board of Directors	All asset leasing or financing arrangements (whatever value) must also be approved by the Chief Finance Officer.
1.4	Management of individual capital projects	Allocated Capital Project Manager	Project Monitoring by Capital Programme Committee
1.5	Management of assets under construction	Allocated Capital Project Manager	Project Monitoring by Capital programme
1.6	Maintenance of Trust Asset register	Chief Finance Officer	

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1.7	<p><b>Approval of Asset Disposals</b> Land &amp; Buildings (any value)</p> <p>Other – where the asset has a residual value or there is a potential write off of value</p> <p>Other – where the asset has no residual value and there is no write off value</p>	<p>Board of Directors</p> <p>Chief Finance Officer</p> <p>Care Group Director after notification to the Head of Procurement</p>	<p>The Deputy Director of Procurement is responsible for ensuring the Trust receives best value from disposals and so must be notified of potential disposal where an asset may have any value.</p> <p>The Chief Finance Officer must always be informed, by way of an Asset Disposal Form, of any asset disposals to enable the asset register to be updated. The Financial Controller must confirm on the Asset Disposal Form the residual book value of the asset.</p>
1.8			
<b>2.0</b>	<b>Contracts for expenditure, including intra NHS trading</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
2.1	Financial appraisal of companies identified as potential tenderers	Chief Finance Officer	Delegated to Head of Procurement
2.2	Maintenance of list of approved potential suppliers	Chief Finance Officer	Delegated to Head of Procurement
2.3	<p>Authorisation of less than the requisite number of quotes and/or tenders, including single tenders/quotes:</p> <p>For individual contracts up to £1,500,000</p> <p>For individual contracts up to £2,499,999</p> <p>For individual contracts over £2,500,000</p>	<p>Chief Finance Officer</p> <p>Chief Executive Officer</p> <p>Board of Directors</p>	Regular report to the Board of all recorded incidents of between £1,500,000 and £2,500,000
2.4	Monitoring the use of single tender/single quote action	Audit and Risk Committee on behalf of the Board of Directors	
2.5	Receipt of Tenders	Chief Finance Officer	
2.6	Opening of Tenders	Any two from the list of trust officers authorised by the Chief Finance Officer to open tenders	As defined by Chief Finance Officer, ensuring independence from procurement process

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2.7	Permission to consider late tenders	Chief Executive Officer	With advice from Chief Finance Officer
2.8	Tender ratification and award, including authorisation of any actions resulting from post tender clarification:		
	Up to delegated budget holder limits Up to £1,500,000 Up to £2,499,999 Over £2,500,000	Budget holders Chief Finance Officer Chief Executive Officer Board of Directors	Post tender clarification will be led by Chief Finance Officer or his/her delegate. Process overseen by Head of Procurement
2.9	Signing of Contracts (including letters of intent) Up to delegated budget holder limits Over delegated budget holder limits	Budget holders Chief Finance Officer or Chief Executive Officer	All building/works projects above £500,000 should be sealed: Other contracts may be sealed if in the interest of the Trust
2.10	Approval of variation or extensions to the use of existing approved contract: <ul style="list-style-type: none"> <li>All Contract Variations up to £1,500,000</li> <li>Variations of over 5% where the revised contract value is up to £2,499,999</li> <li>Variations of over 5% where the revised contract value is over £2,500,000</li> </ul>	Budget holders up to delegated limits then CFO Chief Finance Officer up to limits, then CEO or Board Chief Executive Officer Board of Directors	After taking advice from the Head of Procurement  All variations to be assessed over the life of the contract such that multiple variations are consolidated and measured against the stated limits
2.11	Sealing of Documents	Two directors (the Chief Executive and other Executive Board Director) or One Executive Board Director and the Trust Secretary	
<b>3.0</b>	<b>Contracts for income, including intra NHS trading</b>	<b>Delegation Arrangements</b>	<b>Additional information</b>
3.1	Approval of Healthcare Contracts	Chief Executive Officer or Chief Finance Officer	Following acceptance of commercial terms by Chief Finance Officer
3.2	Approval of all other income contracts including research & development	Budget holders up to delegated limits	This may be delegated to the Chief Finance Officer

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3.3	Approval of variations to Acute healthcare and all income contracts	Chief Executive Officer or Chief Finance Officer	
3.4	Authorisation of individual Credit Notes relating to healthcare contracts	Chief Executive Officer or Chief Finance Officer	
	Invoicing adjustment to “on-account” invoicing under NHS Standard Contract.  Otherwise: E.g. if relating to a pricing discount or loss of potential income then: Up to £1,500,000 Up to £2,499,999 Over £2,500,000	Chief Finance Officer  Chief Finance Officer Chief Executive Officer Board of Directors	Authorisation of Credit Notes below £25,000 may be delegated by the Chief Finance Officer
3.5	Approval and variation of all contracts for recharges of costs and income generation	Budget holders up to delegated limits Chief Finance Officer	Training income and Training recharges will be managed in accordance with a policy approved by the Chief People Officer
<b>4.0</b>	<b>Purchasing and payments (excluding Capital) of Budgeted Expenditure</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
4.1	Authorisation of Requisitions (limits include irrecoverable VAT)  For individual contracts up to £1,500,000 For individual contracts up to £2,499,999 For individual contracts over £2,500,000	Budget holders up to delegated limits Chief Finance Officer Chief Executive Officer Board of Directors	NOTE: Delegated authority to commit the Trust is only available where the proposed expenditure is within budget. Written authority is required from the Chief Finance Officer before incurring expenditure above the budgeted limit.  Heads of Corporate Departments, Care Group Directors and Care Group Directors of Finance have key responsibilities for monitoring budgets and ensuring budget holders are aware of this limitation on approvals.

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	<p>The maximum delegated limits which may be varied downwards by the CEO or CFO are:</p> <p>Up to £50,000</p> <p>Up to £250,000</p> <p>Up to £1,500,000 Up to £2,499,999 Above £2,500,000</p>	<p>Schemes of delegation within these limits may be determined by Care Group Directors, DoEF and Heads of Corporate Departments but such delegation must be approved by CFO before implementation.</p> <p>Executive Directors (including Care Group Directors) with restricted powers of delegation.</p> <p>Chief Finance Officer Chief Executive Board of Directors</p>	<p>Expenditure of £50k and above to be certified as being within budget by the Care Group DOF or by the Deputy Director of Finance</p> <p>Specific arrangements for delegating authority for amounts below £20,000 but only if agreed by the CFO and where it can be demonstrated that financial control will not be compromised. To be notified to the Audit and Risk Committee</p>
4.2	<p>For charity spend, limits are:</p> <p>Up to £1,000 Up to £10,000</p> <p>Up to £50,000</p> <p>Up to £90,000</p> <p>Up to £1,500,000 Up to £2,499,999 Above £2,500,000</p>	<p>Two Fund Advisors Three Fund Advisors and Charity Director</p> <p>All above, and Care Group Manager/Matron and Charity Grants Panel</p> <p>All above, and Care Group Director or Executive Director and Charity Committee</p> <p>All above, and Chief Finance Officer All above, and Chief Executive All above, and Board of Directors</p>	<p>To be notified to the Audit and Risk Committee</p>

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4.3	Authorisation of individual invoices due for payment where the approved order process has not been followed	Not Allowed	All purchases should be made via Trust eProc ordering system, JAC or Atticus. Only in extenuating circumstances should such invoices be presented for authorisation to the CFO or the Deputy Chief Finance Officer
4.4	Authorisation of petty cash payments	Authorisation by line manager (must be budget manager or have delegated authority)	
4.5	Authorisation of expenses claims	Authorisation by line manager (must be budget manager or have delegated authority)	Only via Trust On-line System
4.6	Authorisation of time sheets	Authorisation by line manager (must be budget manager or have delegated authority)	
4.7	Authorisation of Agency expenditure	<u>Non ward and non clinic based agency staff</u> : approval by any 2 of CEO, CFO, Chief Nursing Officer, Chief People Officer, Chief Medical Officer and Chief Operating Officer  <u>Ward and clinic based agency staff</u> : ordered through NHS Professionals or eProc as approved by Care Groups Directors of Nursing	
4.8	Authorisation of Overtime and additional hours	Pre-Authorisation only via Trust On-line System	
<b>5.0</b>	<b>Staff appointments, secondments and severance payments</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
5.1	Clinical appointments	To be approved by any two of CEO, CFO, Chief Nursing Officer, Chief People Officer, Chief Medical Officer and Chief Operating Officer	No appointment can be made unless it is within the budgeted establishment and the appointment has followed the process as established by the Chief People Officer  Any recruitment/retention premiums outside of national Terms and Conditions also requires Chief People Officer and CEO approval.

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5.2	Non-clinical appointments	To be approved by any one of CEO, CFO, Chief Nursing Officer, Chief People Officer, Chief Medical Officer and Chief Operating Officer	No appointment can be made unless it is within the budgeted establishment and appointment has followed the process as established by the Chief People Officer  Any recruitment/retention premiums outside of national Terms and Conditions also requires Chief People Officer and CEO approval.
5.3	Severance payments	Nominations and Remuneration Committee approve all severance payments (contracted and non-contracted) for the Chief Executive and Directors. It also delegates other contracted and non-contracted severance payments as follows: <ul style="list-style-type: none"> <li>• For all staff below Director level approval of contractual severance payments delegated to the Chief Executive, the Chief Finance Officer and the Chief People Officer.</li> <li>• The Committee will approval non-contractual severance payments over £50,000. Approval for non-contractual severance payments below £50,000 will be delegated to the Chief Executive and the Chief Finance Officer and Chief People Officer.</li> <li>• Once authorised, authority to pay will only be valid if signed by both the Chief People Officer and by the CFO and having obtained the regulatory approval where required by relevant policies and procedures.</li> </ul>	Severance payments resulting from industrial tribunals need not go to Nominations and Remunerations Committee but must still be signed by both the Chief People Officer and by the CFO.
<b>6.0</b>	<b>Income and debt write off</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
6.1	Invoicing	Chief Finance Officer	All invoices to be raised by the Finance Department
6.2	Requests for Invoicing to be raised	Budget Managers may raise a request for Finance to generate an invoice. For clarity no-one outside of Finance is authorised to raise an invoice.	All requests for invoicing should be passed to Finance.

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6.3	Authorisation of discounts, credit notes (non healthcare income)	Chief Finance Officer	See under 3.4 for Credit Notes related to Healthcare income
6.4	Collection of debts and use of debt collection agencies	Chief Finance Officer	
6.5	Authorisation of individual debt write off		This delegation also applies to the effective write off through lack of invoicing for income to which the Trust is entitled. Whether it occurs through action, lack of action or the passing of time
	Up to £50,000 Up to £150,000 Up to £349,999 Over £350,000	Financial Controller or Director of Finance Chief Finance Officer Chief Executive Board of Directors	To be reported to the Audit and Risk Committee.
<b>7.0</b>	<b>Losses and special payments</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
7.1	Authorisation of individual losses and special payments		All special payments subject to having obtained the regulatory approval where required by relevant policies and procedures.
	Up to £10,000 Up to £150,000 Up to £349,999 Over £350,000	Head of Legal Services Chief Finance Officer Chief Executive Board of Directors	delegated to the for payments resulting from legal claims. To be reported to the Audit and Risk Committee
7.2	Authorisation of clinical negligence payments	Chief Finance Officer	To be reported to the Audit and Risk Committee
7.3	Monitoring of losses and special payments	Audit and Risk Committee	On behalf of the Board of Directors
7.4	Authorisation of early retirement payments to staff		
	Up to £150,000 Up to £349,999 Above £350,000	Chief Finance Officer Chief Executive Board of Directors	Only after advice from the Chief People Officer
7.5	Authorisation of redundancy and all other termination payments to staff	Nominations and Remuneration Committee and having obtained the regulatory approval where required by relevant policies and procedures.	Only after advice from the Chief People Officer and reference to the Severance Protocol

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7.6	Authorise payment of salary underpayment corrections	Chief Finance Officer	Only after advice from the Chief People Office
<b>8.0</b>	<b>Budgetary control</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
8.1	Delegation of budgets	Chief Executive and Chief Finance Officer	
8.3	Authorisation of budget virement	Chief Finance Officer	This may be delegated by the CFO to the Deputy Director of Finance or the CGDOFs
8.4	Overall Trust budget and planning process	Chief Finance Officer	
8.5	Staff expenses, including relocation expenses	Routine expenses - approval by line manager Relocation expenses – approval by Chief People Officer	Routine expenses must be claimed via the Trust's on-line expense claim system. Details available from Payroll. Relocation expenses must be claimed according to the Trust's Relocation Expenses Policy
<b>9.0</b>	<b>Stores and stock controls</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
9.1	Management and control systems for stores and stocks	Chief Finance Officer	Delegated to Head of Procurement. Orders may be generated automatically based on agreed minimum and maximum stock quantities.
<b>10.0</b>	<b>Bank account and payment methods</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
10.1	Opening of bank accounts	Chief Finance Officer	
10.2	Signing of cheques, BACS schedules and PGO authorisation	Chief Finance Officer	This may be delegated within the Finance Department.
<b>11.0</b>	<b>Bank account and working capital facilities fees and charges</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
11.1	Approval of Fees and Charges	Chief Finance Officer	
<b>12.0</b>	<b>Standards of business conduct</b>	<b>Delegation arrangements</b>	<b>Additional information</b>

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12.1	Maintenance of register of interests and secondary employments		
	Board of Directors All other staff	Chief Executive Chief Executive	Maintained by the Trust Secretary
<b>12.2</b>	Maintenance of gifts and hospitality registers		
	Board of Directors All other staff	Chief Executive Chief Executive	Maintained by the Trust Secretary
<b>13.0</b>	<b>Insurances</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
13.1	Insurance arrangements	Chief Finance Officer	
<b>14.0</b>	<b>Fraud and irregularity</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
14.1	Counter Fraud and corruption work	Chief Finance Officer	It is expected that Local Counter Fraud Service would be involved in any investigation.
14.2	Investigation of suspected cases of irregularity not related to fraud or corruption	Chief People Officer	
<b>15.0</b>	<b>Investments</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
15.1	Approval of Treasury Policy (CG401)	Board of Directors	After review by the Audit and Risk Committee
15.2	Investment Decisions	Chief Finance Officer	
<b>16.0</b>	<b>Borrowings</b>	<b>Delegation arrangements</b>	<b>Additional information</b>
16.1	Approval of loans and loan facilities, (including working capital facilities)	Board of Directors	
16.2	Use of loans and loan facilities as approved by the Board of Directors	Chief Finance Officer	
16.3	Use of leasing and non-conventional funding	Chief Finance Officer	

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17.0	Credit cards	Delegation arrangements	Additional information
17.1	Approval for new credit card	Director of Finance	
17.2	Approval of single transaction value:- Below £1,000 £1,001 and above	Card holder Director of Finance	The 'second pair of eyes' principle applies, CFO expenditure needs sign off by another Executive Director and DoF expenditure by the CFO  Delegated authority is given to the Deputy Chief People Officer and Recruitment Service Manager for UK Border Authority transactions only at a single transaction limit of £4,000
17.3	Approval of total daily transaction value Below £10,000 £10,001 and above	Card holder Director of Finance	The 'second pair of eyes' principle applies, CFO expenditure needs sign off by another Executive Director and DoF expenditure by the CFO  Delegated authority is given to the Deputy Chief People Officer and Recruitment Service Manager for UK Border Authority transactions only at a daily limit of £25,000

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**TABLE 2 – Tendering and contracting thresholds**

(a)	(b) Up to £10,000	(c) £10,001 - £75,000	(d) £75,001 Trust Tender Threshold (see column f)	(e) Over FTS limit (See column f)	(f) Public Contract Regulations 2015 (under FTS)
Services & Supplies	Single written quotation	3 written competitive quotations	3 formal tenders	Normally minimum of 5 tenders through FTS	£139,668 and over
Works	Single written quotation	3 written competitive quotations	3 formal tenders	Normally minimum of 5 tenders through FTS	£5,372,609 and over (£884,720 and over for small lots)

- For tendering and contractual purposes, the Trust is a Governmental Procurement Authority (GPA) and the procurement thresholds shown for Services and Supplies are those for GPAs.
- Even where estimated amounts are below legislative thresholds, quotes and tenders are to be conducted inline with Public Contract Regulation 2015 and/or The Procurement Act 2023 depending upon when tenders or contracts are awarded. Definitions of outputs required from the goods or services, pre-defined evaluation criteria should be defined with evaluation and awards conducted in a transparent and equitable manner capable of withstanding audit and challenge by unsuccessful suppliers.
- For all levels the figures shown are those for the aggregate of the requirement. Artificial subdivision of lots into smaller lots to stay below thresholds of the applicable legislation
- Where requirements are for a combination of supplies / services and works, the estimated value of the majority value within the total determines which procedure and, thereby, which threshold to apply.

## Certification

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I \_\_\_\_\_ certify that I have read, understood and will comply with the Standing Financial Instructions dated May 2026

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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<b>Title:</b>	<b>NHS Oversight Framework 2026/27</b>
<b>Agenda item no:</b>	9
<b>Meeting:</b>	Board of Directors
<b>Date:</b>	27 May 2026
<b>Presented by:</b>	Andrew Statham, Chief Strategy Officer
<b>Prepared by:</b>	Katie Birtwhistle, Head of Transformation

<b>Purpose of the Report</b>	To review the changes to the NHS Oversight Framework for 2026-7 and possible impact on Trust benchmarked performance and implications for NHSE oversight
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<b>Report History</b>	Executive Management Committee, 11 May 2026
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<b>What action is required?</b>	
Assurance	
Information	X
Discussion/input	X
Decision/approval	

<b>Resource Impact:</b>	<i>Will inform resource allocation</i>
<b>Relationship to Risk in BAF:</b>	
<b>Corporate Risk Register (CRR) Reference /score</b>	4182
<b>Title of CRR</b>	<i>Risk of achieving financial sustainability</i>

<b>Strategic objectives</b> This report impacts on (tick all that apply)::	
Delivering the highest quality care for all	<b>X</b>
Supporting our people to thrive	
Partnering for impact	<b>X</b>
Driving improvement and enabling innovation	<b>X</b>
Building a sustainable future together	
<b>Well Led Framework applicability:</b>	
Not applicable <input type="checkbox"/>	
1. Leadership <input type="checkbox"/>	2. Vision & Strategy <input type="checkbox"/>
3. Culture <input type="checkbox"/>	4. Governance <input type="checkbox"/>
5. Risks, Issues & Performance <input type="checkbox"/>	6. Information Management <input type="checkbox"/>
7. Engagement <input type="checkbox"/>	8. Learning & Innovation <input type="checkbox"/>

<b>Publication</b>			
Published on website		Confidentiality (FoI)	Private
			Public

## 1 Executive Summary

- 1.1 The NHS Oversight Framework was first published in September 2025 as a framework for assessing and benchmarking providers against key areas of quality and performance and driving improvement and accountability in these areas in a clear and transparent way. The initial publication set out the scoring framework against 5 domains for NHS and foundation trusts, placing all trusts in league tables according to these scores. Whilst RBFT scored well across most domains with an unadjusted segment score of 1 (highest), it was capped at 3 due to an override for its financial deficit forecast.
- 1.2 NHSE have published updated metric scores quarterly since September. RBFT's 2025-6 performance remains very high for Q3 and has shown an improving picture overall since Q1 metrics were published.
- 1.3 Significant changes to the metrics are planned for 2026-7, therefore it is not clear to what extent this will alter the Trust's overall scores and ranking. Q1 2026-7 metrics should be published by Sept 26. The financial deficit override will remain so until this changes the Trust will remained capped at segment 3 regardless of metric performance.
- 1.4 In addition to this, ICBs will now also be included in the oversight framework and will likewise be awarded segmentation scores. All organisations will be required to complete capability self-assessments (May-Jun) which will be submitted to the region for capability scoring. These will be used in conjunction with segment scores to decide the level of oversight the Trust will be subject to.
- 1.5 Oversight responses will include incentives and additional freedoms for Trusts scoring highly, with increased scrutiny and mandated support packages for Trusts scoring poorly. The final decision regarding oversight response will happen at a national level.

## 2 NOF Segmentation Scoring 2025-6

- 2.1 NHSE have updated NOF segmentation scores on a quarterly basis, most recently in March 26 (Q3 25/26). The dashboard below shows that the RBFT has maintained a strong position across most domains, with its average metric score improving from 1.95 to 1.50 and moving from 20<sup>th</sup> to 6<sup>th</sup> Acute Trust overall. However, due to planned financial deficit forecast position, the Trust segment remains capped at 3.

Select trust(s)		Select metric(s)		View metric timeseries table				
Royal Berkshire NHS Foundation Trust (RHW)		All						
Trust	Description	Quarter	Q3 2025/26		Q2 2025/26		Q1 2025/26	
		Units	Metric score	Rank	Metric score	Rank	Metric score	Rank
Royal Berkshire NHS Foundation Trust (RHW)	Average metric score	score	1.50	6 out of 134	1.67	9 out of 134	1.95	20 out of 134
	Unadjusted segment	segment	1.00		1.00		1.00	
	Adjusted segment	segment	3.00	28 out of 134	3.00	29 out of 134	3.00	34 out of 134
	Access to services domain score	score	1.07	3 out of 131	1.39	7 out of 131	1.81	22 out of 131
	Finance and productivity domain score	score	1.66	19 out of 134	1.82	32 out of 134	2.39	74 out of 134
	Effectiveness and experience domain score	score	2.31	83 out of 134	2.44	97 out of 134	2.47	105 out of 134
	Patient safety domain score	score	1.99	21 out of 134	1.86	14 out of 134	2.03	19 out of 134
	People and workforce domain score	score	1.10	2 out of 134	1.13	4 out of 134	1.12	2 out of 134
	Access to services domain segment	segment	1.00		1.00		1.00	
	Finance and productivity domain segment	segment	1.00		2.00		3.00	
	Effectiveness and experience domain segment	segment	3.00		3.00		3.00	
	Patient safety domain segment	segment	1.00		1.00		1.00	
	People and workforce domain segment	segment	1.00		1.00		1.00	

- 2.2 Across the 5 domains, 2 domains (Access to Services and People & Workforce) have metrics which are all NOF Score 1, GREEN. The breakdown of the other 3 domains where metrics are not 'GREEN' are given below with the metric values and ratings. These are areas that should be considered for an improvement focus.

Domain	Description	Report date	Metric Value	Metric Score
Effectiveness & Experience	Average number of days from discharge ready date to actual discharge date (inc 0 days)	Dec-25	1.03 days	2.93
Effectiveness & Experience	Summary Hospital level Mortality Indicator (SHMI)	Oct24-Sep25	-	2
Effectiveness & Experience	CQC inpatient survey satisfaction rate	2024	-	2
Finance & Productivity	Planned surplus/ deficit	2025-6	-3.24%	4
Finance & Productivity	Combined finance	Q3 2025-6	-	2
Patient Safety	Number of MRSA bacteraemia cases (12m)	Jan 25 - Dec 25	5	3.23
Patient Safety	Proportion of E. coli bacteraemia	Jan 25-Dec 25	1.01	2
Patient Safety	Proportion of C. difficile infections	Jan 25 - Dec 25	1.31	3.28

### 3 Changes to NOF metrics 2026-7

- 3.1 In the 2026-7 NOF, metrics have been updated to align with the NHS Medium Term Planning Framework. Overall, there have been significant changes to the metrics with 7 old metrics removed and 19 new metrics added out of 39 metrics. Some of these are contextual only and do not contribute towards segmentation scores, however, the number of scored vs contextual metrics have increased overall so more areas will count towards the overall segment score. There has also been a move away from relative scoring where possible: previously, only 50 trusts could get a 1 in any score, but now all trusts could score 1 if they were meeting the relevant national target.
- 3.2 ICBs will be included and scored within the NOF for the first time. ICBs have slightly different domains and metrics relevant to commissioning decisions rather than operational performance delivery. For example, ICBS have the metric “% change in overall waiting list size vs previous year”, as opposed to the Trust metric of “% of patients waiting less than 18 weeks for care”. A table of the changes to the acute trust metrics for 2026-7 is provided in [Appendix 1](#).

### 4 Provider Capability Assessments

- 4.1 Providers will be asked to complete an annual self-assessment against a range of expectations across the 6 domain areas of the 'Insightful Provider Board' (May-Jun). The regional team will review the self-assessment, the evidence behind it, the region's own views of the Board, the provider's track record, and the views of any relevant third parties. Following this, the region assigns a capability rating to the provider. This rating reflects not only how the board is overseeing the organisation, but also how well it is supporting system working and collaboration. Ratings will be assigned: Green/ Amber-Green/ Amber-Red/ Red. This should be completed by August 26. These ratings will be reviewed annually, but could be revised in-year where new information emerges. The rating will be published alongside segment and league table position. This combined rating will determine the oversight response.

### 5 Oversight Response

- 5.1 Organisations that score well in delivery and capability assessments will receive greater freedoms and incentives e.g. eligibility to apply for advanced foundation Trust status, access to capital flexibilities, lighter touch processes for taking on responsibilities for NHS Property Services estates where appropriate.
- 5.2 Where challenges are identified in delivery and/or capability NHSE will increase scrutiny and provide support to secure improvement e.g. access to improvement support through GIRFT, NHS IMPACT & GIRFT Academy. Where performance and / or capability remain persistently low or risk escalates, freedoms maybe curtailed and formal consequences applied e.g. mandated improvement support and/or enforcement action. Providers in segment 4 delivery and 'red' capability enter the NPIP.

## **6 Conclusion**

- 6.1 The RBFT continues to perform strongly against the performance metrics overall for the NOF 2025-6, despite the segmentation override
- 6.2 In September 2026 the Q1 2026-7 NOF segmentation scores will be published; it is unclear at this stage how this will impact the Trust's benchmarked position or what oversight measures this may provoke. Regardless of unadjusted segmentation score, the RBFT will be capped at a max of segment 3 due to the financial override still being in force.
- 6.3 It is recommended that the list of new metrics is reviewed for any areas of concern. Where these are identified, those metrics should be prioritised for improvement work to ensure the Trust is in the best position.

## **7 Appendices**

### **[Appendix 1: List of metrics Changes 2026-7 \(acute trusts\)](#)**

## Appendix 1: List of metric changes 2026-7 (Acute Trusts)

Metric	Changes 2025-6 to 2026-7
<b>Domain 1: Population Health, Prevention &amp; Reducing Inequality</b>	
% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	No change
<b>Domain 2B: Access to Services</b>	
% of patients waiting less than 18 weeks for care	No change
% of patients waiting less than 18 weeks for care versus target (contextual)	No change
% of patients waiting over 52 weeks for care	No change
% of diagnostic referrals waiting over 6 weeks	<i>Moved domain from prevention to access</i>
% of patients meeting the 28 day faster diagnosis standard	No change
% of patients treated within 62 days of referral	No change
% of patients admitted, discharged or transferred within 4 hours	No change
<b>% of patients cared for in inappropriate physical spaces</b>	<b>NEW</b>
<b>Domain 3: Experience of Care</b>	
CQC inpatient survey satisfaction rate	No change
<b>Mean length of stay for adult acute and psychiatric intensive care unit patients</b>	<b>NEW</b>
<b>Patient flow mean length of stay for older adult acute discharges</b>	<b>NEW</b> <i>Av LoS 70+ = 1.8, Quartile 2*</i>
<b>Patient flow % of intermediate care beds occupied by patients without criteria to reside</b>	<b>NEW</b> <i>Bed occupancy classed as clinically ready for discharge =25.6%, Quartile 3*</i>
<b>Domain 4: Effectiveness of Care</b>	
Summary Hospital Mortality Indicator	No change
<b>% of pregnant women with a planned induction that are delayed</b>	<b>NEW</b>
<b>% of incidents managed via hear and treat or see and treat</b>	<b>NEW</b>
<b>% of acute adult discharges followed up within 72 hours</b>	<b>NEW</b>
<b>30 day readmission rate</b>	<b>NEW</b>
<b>Discharge 14 day readmission rate</b>	<b>NEW</b>
<b>Domain 5: Patient Safety</b>	
<b>Breadth and depth of clinical audit outliers</b>	<b>NEW</b>
Number of cases of MRSA in the last 12M	No change
Rate of e-coli	No change
Rate of c-difficile	No change
<b>Rate of inpatient falls that cause harm (contextual)</b>	<b>NEW</b>
<b>% of inpatients to acquire a new grade 3 or 4 PU (contextual)</b>	<b>NEW</b>
<b>% of safety incidents causing harm (contextual)</b>	<b>NEW</b>
<b>NHS staff survey raising concerns sub-score</b>	<b>NEW</b>

<b>Domain 6: Finance Productivity &amp; Innovation</b>	
Planned surplus or deficit	No change
Variance to plan year-to-date	No change
Relative cost difference (NCCI)	No change
Implied productivity growth (Contextual)	No change
<b>% of clinical trials set up within 150 days</b>	<b>NEW</b>
<b>Data Quality Maturity Index</b>	<b>NEW</b>
<b>Domain 7: People</b>	
Sickness absence rate	No change
NHS staff survey engagement theme score	No change
National Education and Training Survey satisfaction rate	Change from contextual to scoring
<b>NHS staff standards score</b>	<b>New</b>
<b>Healthcare Worker Flu Vaccination Rate</b>	<b>New</b>
<b>Temporary staffing cost as a % of total pay bill</b>	<b>New</b> <i>Overall Temporary Staff spend as a % of Total spend =4.5%, (Green) Peer median = 9.1%*</i>

*\*Current Model Hospital data for reporting period August 2025*

<b>2025-6 metrics which have been removed</b>
Under 18 Elective wait list
Percentage of emergency department attendances spending over 12 hours in the department
Average number of days from discharge ready date and actual discharge date
National Maternity Survey score
Readmission rate band
CQC SAFE inspection score
Rates of patients acquiring new pressure ulcer

<b>Title:</b>	<b>NHS England Self-Certification 2025/26</b>
<b>Agenda item no:</b>	10
<b>Meeting:</b>	Board of Directors
<b>Date:</b>	27 May 2026
<b>Presented by:</b>	Frances Khatcherian, Chief Finance Officer Caroline Lynch, Trust Secretary
<b>Prepared by:</b>	Frances Khatcherian, Chief Finance Officer Caroline Lynch, Trust Secretary

<b>Purpose of the Report</b>	To approve the self-certification statements for 2025/26
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<b>Report History</b>	N/A
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<b>What action is required?</b>	The Board is asked to approve the self-certification statements for 2025/26
<b>Assurance</b>	
<b>Information</b>	
<b>Discussion/input</b>	
<b>Decision/approval</b>	✓

<b>Resource Impact:</b>	None
<b>Relationship to Risk in BAF:</b>	Not applicable
<b>Corporate Risk Register (CRR) Reference /score</b>	
<b>Title of CRR</b>	

<b>Strategic objectives</b> This report impacts on (tick all that apply)::				
Delivering the highest quality care for all				✓
Supporting our people to thrive				✓
Partnering for impact				✓
Driving improvement and enabling innovation				✓
Building a sustainable future together				✓
<b>Well Led Framework applicability:</b>			Not applicable <input type="checkbox"/>	
1. Leadership <input type="checkbox"/>	2. Vision & Strategy <input type="checkbox"/>	3. Culture <input type="checkbox"/>	4. Governance <input type="checkbox"/>	
5. Risks, Issues & Performance <input checked="" type="checkbox"/>	6. Information Management <input type="checkbox"/>	7. Engagement <input type="checkbox"/>	8. Learning & Innovation <input type="checkbox"/>	
<b>Publication</b>				
Published on website		Confidentiality (FoI)	Private	Public <input checked="" type="checkbox"/>

## 1 Background

- 1.1 The Compliance Framework published by NHS England requires foundation trusts to submit an Annual Plan each year. The Plan is used by NHS England primarily to assess the risk that a foundation trust may breach its Licence in relation to finance and governance. NHS England will also assess the quality of the underlying planning processes.
- 1.2 As part of the submission the Board is required to self-certify against a number of prescribed statements as either 'confirmed' or 'not confirmed'.
- 1.3 If the Board feels it is unable to fully certify a particular statement, the guidance states that the Board
- '...should make an alternative declaration by amending the self-certification as necessary and including any significant prospective risks and concerns the FT has in respect of delivering quality services and effective quality governance and
- ...must provide a commentary explaining the reasons for the absence of a full self-certification and the actions it proposes to take to address it.'
- NHS England may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the Trust.'
- 1.4 The Board of Directors is required to confirm self-certification against the requirements of General Condition G6 and Continuity of services 7 of the NHS Provider Licence and to confirm the self-certification against FT4 and the Training of Governors, as appropriate.

## 2 Comment

- 2.1 The Board statements are listed in the appendices to this report, together with a commentary, supporting the following declarations:
- *General Condition 6 – Systems for compliance with license conditions* – 'confirmed'
  - *Continuity of services 7 – Availability of resources* – 'confirmed'
  - *FT4 Declaration – Corporate Governance Statement* – 'confirmed'
  - *Training of Governors* – 'confirmed'
- 2.2 The Board is invited to consider whether it is able to certify each statement or whether further evidence is required. Should the Board be unable to fully certify then amendments to the appropriate statement and supporting commentary should be considered.

## 3 Recommendation

- 3.1 The Board is recommended to self-certify that the four board statements for 2025/26 can be marked as 'confirmed'.

## 4 Attachments

- 4.1 The following is attached to this report:
- Self-Certification Statement for May 2026

## Declarations required by General Condition 6 (GC6) and Continuity of Services 7 (CoS7) of the NHS Provider Licence

Statement	Lead	Commentary
<p>1 &amp; 2 <b>General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)</b></p> <p>Conditions G6(2): NHS providers must have processes and systems that:</p> <ul style="list-style-type: none"> <li>a) identify risks to compliance with the licence, NHS acts and the NHS Constitution</li> <li>b) guard against those risks occurring</li> </ul> <p>Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).</p>	<p>Frances Khatcherian, Chief Finance Officer</p>	<p>The Trust has in place the systems and processes required to identify risks to compliance with licence conditions and to guard against those risks occurring. The Board has reviewed whether these systems and processes were implemented and effective across 2025/26.</p> <p>The Trust delivered its year-end financial plan for 2025/26. The Board is satisfied that the required governance systems and processes were in place throughout the financial year and that risks to licence compliance were identified and acted upon. The</p> <p>Trust operated within the NHSE Investigation and Intervention framework during the year and engaged constructively with regional and national oversight throughout.</p> <p>Having reviewed the year-end position and the operation of its governance and financial control systems, the Board self-certifies that its processes meet the requirements of General Condition G6(2) and that those systems were implemented and effective in 2025/26.</p>
<p>3 <b>Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)</b></p> <p>(a) After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.</p> <p>(b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is</p>	<p>Frances Khatcherian, Chief Finance</p>	<p>The Trust delivered its planned financial position for 2025/26, with a reported deficit of approximately £(4–5)m against a planned deficit of £(7–8)m, favourable to plan. The Trust's underlying</p>

Statement		Lead	Commentary
	<p>explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3 below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.</p>	<p>Officer</p>	<p>financial position and cash trajectory have, however, required active management and external support during the financial year, and the following factors are relevant to this certification:</p> <p><b>Revenue cash support dependency.</b> The Trust had submitted an application to NHS England for revenue cash support all was approved and received. The Trust's ability to meet its financial obligations through 2026/27 is dependent on this support continuing to be available and on the delivery of the Financial Improvement Programme.</p> <p><b>ICB clawback.</b> The Trust expects Thames Valley ICB to apply a clawback of approximately £13.2m in relation to 2025/26 activity underperformance, expected in Q1 2026/27. This has been factored into the Trust's cash planning and does not alter the Directors' reasonable expectation, but is drawn to attention as a material cash flow event.</p> <p><b>Financial Improvement Programme.</b> The Trust's financial plan for 2026/27 requires delivery of £43.69m of efficiency and improvement savings. The Financial Improvement Programme is the vehicle for this delivery. At the date of this certificate, Month 01 delivery is on plan at £2.13m. The Directors' reasonable expectation is conditional on this programme delivering at the required pace and scale throughout the year.</p> <p>Having regard to the above, the Directors confirm that they have a reasonable expectation that Required Resources will be available, and draw these factors to the attention of commissioners and NHS England as required by Condition G7</p>
<p><i>Cont'd</i></p>	<p>(c) In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.</p>	<p>Frances Khatcherian, Chief Finance Officer</p>	<p>NOTE: HFMA is coordinating with the National Audit Office on the appropriate form of declaration for trusts in this position. The commentary below reflects the Trust's current position. This text should be reviewed and updated once national guidance is issued before final submission.</p>

Statement	Lead	Commentary
		<p>The Trust planned a deficit of £(7.80)m for 2025/26 and delivered a year-end deficit of £(4.52)m — a favourable variance of £3.28m, equivalent to Deficit Support Funding received. Excluding Deficit Support Funding, the underlying position was delivered on plan.</p> <p>This represented the third consecutive year of deficit performance, which has materially depleted working capital. The Trust ended 31 March 2025 with a cash balance of approximately £10m. Through proactive cash flow management with the ICB and critical partners maintained throughout 2025/26, the Trust closed 31 March 2026 with a cash balance of £27m — £14m above the £13m forecast submitted in the December 2025 revenue cash support application.</p> <p>The Trust's 2025/26 CIP plan totalled £40.6m; at the start of the year £27.92m of savings had been formally identified, a gap of £12.68m. CIP has delivered in year, but relied heavily on non-recurrent programmes. Structural cost pressures in pay (underlying overspend approximately £9m, excluding non-recurring NHSE pension reimbursement, with WTE running 210 above plan) and in Networked Care drugs (£8.39m adverse, 36% over plan) carry forward as risks into 2026/27 and are subject to dedicated workstreams within the CFO's Financial Recovery Programme.</p> <p>The Trust maintained rigorous cash management throughout 2025/26, with weekly cash review meetings in place since August 2024. Weekly meetings with the National Provider Support team, SE Regional Finance team and BOB ICS Finance Team, established in January 2025 following an unsuccessful request for revenue cash support in December 2024, helped secure sufficient cash from commissioners to meet Q4 2024/25 needs and continued throughout the year. A 10-point I&amp;E recovery plan was implemented from M6 (September 2025), and the required run-rate improvement was delivered every month from M6 to year end. At the April 2026 CFO System Meeting, it was confirmed that all providers and the ICB across the BOB system delivered their</p>

Statement		Lead	Commentary
			<p>financial plans for 2025/26.</p> <p>The Financial Recovery Programme for 2026/27, comprising 13 workstreams across three themes, has been developed to address the structural cost pressures identified and to secure the Trust's financial sustainability over the medium term. Subject to the foregoing, the Board has a reasonable expectation that the Trust will have the required resources available for the 12-month period from the date of this certificate.</p>

Corporate Governance Statement (FTs and NHS trusts)

1 – Corporate Governance

Statement		Lead	Commentary
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Caroline Lynch, Trust Secretary	Governance arrangements follow best practice and are reviewed against the NHSE Code of Governance and other guidance. The system of governance is subject to review by internal and external audit on an annual basis.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time.	Caroline Lynch, Trust Secretary	The Audit & Risk Committee receives an update at every meeting from internal or external auditors which includes NHSE advice issued. The Chief Executive’s report to the Board also covers national reports, advice and topics.
3	<p><b>The Board is satisfied that the Licensee has established and implements:</b></p> <p>(a) Effective board and committee structures;</p>	Caroline Lynch, Trust Secretary	(a) A Board and Committee structure is in place and terms of reference for each of the committees is reviewed on an annual basis and submitted to the Board for approval.
	(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and		(b) Terms of reference are set for all committees. Matters reserved for the Board, as well as its role in general have been agreed. All directors reporting to the Board have responsibilities set out in job descriptions.
	(c) Clear reporting lines and accountabilities throughout its organisation.		(c) Organisational charts are in place for all corporate and care group directorates which set out reporting lines and accountabilities.
4	<p><b>The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:</b></p> <p>(a) To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively;</p>	Frances Khatcherian, Chief Finance	a) The Trust’s internal control mechanisms and reporting regime to NHS England ensure that this is closely monitored. The Trust is subject to internal and external audit which also

Statement	Lead	Commentary
	Officer	<p>monitors performance in this area. Actions to improve compliance identified in previous years have been implemented. Consequently, the External Auditors are in the process of completing their work in the year-end report compliance with regards to this matter.</p> <p>The Trust received a rating of 'good', in its Use of Resources report from NHS England, carried out during 2019/20.</p>
Cont'd	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	Katie Prichard-Thomas, Chief Nursing Officer / Dom Hardy, Chief Operating Officer  b) The Trust Board receives a monthly Integrated Performance Report. This is in addition to specific exception reports on operational issues.
Cont'd	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	Katie Prichard-Thomas, Chief Nursing Officer  c) The Trust has a governance structure linking the Board, key committees charged with responsibility for oversight of operations (the Quality Committee, Finance & Investment Committee, Audit & Risk Committee and People Committee, through to the Executive Structure (the Executive, the Executive Management Committee and the Quality Governance Committee, Executive performance meetings with Care Group Clinical Governance and performance meetings). There are clearly defined reporting lines and accountabilities between the Board, its Committees and the Executive Management Team within the overall governance structures of the Trust.
Cont'd	(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	Frances Khatcherian, Chief Finance Officer  d) The Trust has established financial decision-making processes including a Finance & Investment Committee with delegated authority from the Board, and a monthly Chief Finance Officer report and Integrated Performance Report presented to the Board and its committees.

Statement		Lead	Commentary
Cont'd			<p>In recognition of the Trust's financial position, the Board took significant additional steps to strengthen financial controls and oversight during 2025/26: weekly cash flow monitoring was maintained with active oversight from the National Provider Support Team, South East Regional Finance Team and BOB ICS Finance Team; an independent cash flow and working capital review was commissioned from Deloitte, with all recommendations actioned; and a Restructuring Oversight Committee of the Board was established to provide dedicated governance of the financial recovery programme.</p> <p>For 2026/27, the Board has further strengthened its financial governance through the establishment of the Financial Improvement Programme — a 13-workstream programme with a target of £45m+ — and its associated governance structure, including the Executive Improvement Group meeting weekly, Gate reviews at three programme milestones, and a Head of PMO appointed to provide programme assurance. A Financial Director of Improvement is to be appointed with dedicated responsibility for programme delivery, and a Deputy Director of Financial Control holds elevated accountability for the day-to-day financial control environment.</p> <p>The going concern assessment for the 2025/26 Annual Report and Accounts has been finalised in conjunction with the External Auditors. The disclosure reflects the Trust's dependency on continued NHSE revenue cash support and the delivery of the Financial Improvement Programme, both of which are material uncertainties that have been disclosed in the financial statements in accordance with the guidance from HFMA and the National Audit Office.</p>
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	Frances Khatcherian, Chief Finance	e) A monthly Integrated Board Performance Report, including quality, access, operational performance, staffing information, exception reports and a Chief Finance Officer report, is produced for the Board. Prior to the Board,

Statement	Lead	Commentary
	Officer	<p>performance is monitored through monthly performance and finance review meetings with the Executive team and care groups.</p> <p>The Trust acknowledges that data quality and the timeliness of management information were identified as material weaknesses in 2025/26 — in particular, the absence of a single connected view of activity, income and workforce meant that financial underperformance was not always visible at the level of detail or speed required to enable timely corrective action. The Board has commissioned a programmatic response through the Financial Recovery, Data Assurance and Operational Intelligence (FRDAOI) programme, which is actively monitored by the Audit and Risk Committee and is a workstream within the Financial Improvement Programme.</p> <p>For 2026/27, the programme is delivering automated data quality checks, data lineage documentation and Power BI dashboards at care group level. The target is for all care groups to have access to an integrated activity, workforce and finance dashboard by Gate 3 (year end 2026/27). Data quality improvement has been routinely monitored by the Audit and Risk Committee throughout 2025/26, and this oversight will continue.</p>
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Katie Prichard-Thomas, Chief Nursing Officer	f) The Trust identifies key risks through the Board Assurance Framework and the Corporate Risk Register. This identifies any risk to compliance with the conditions of the license. The Operational Plan sets out key risks.
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	Frances Khatcherian, Chief Finance Officer	g) The Board monitors delivery against financial plans through its Finance & Investment Committee and through the Board itself, with particular focus on those areas identified as of greatest risk. Monthly performance reviews of care groups and corporate departments support in-year tracking against plan.

Statement	Lead	Commentary	
		<p>For 2025/26, the Trust submitted several iterations of the annual financial plan in line with national timetables, with a final submitted deficit plan of £7.8m. The Trust delivered its year-end position in line with plan, with a reported deficit of approximately £(4–5)m — favourable to plan — supported by the 10-point I&amp;E action plan introduced at Month 6.</p> <p>For 2026/27, the Financial Improvement Programme provides the primary vehicle for delivery against the financial plan, with Gate reviews at three milestones (early summer, autumn and year end) providing structured internal and external assurance points. The programme's benefits register is independently validated by the Deputy Director of Financial Control before schemes are counted as confirmed savings. The Trust's quarterly forecast process continues to assess delivery against business plans, and the Finance &amp; Investment Committee receives a monthly programme update alongside the financial performance report. External assurance is provided through the External Auditors, NHSE oversight and the Audit and Risk Committee's review of internal audit findings.</p>	
(h) To ensure compliance with all applicable legal requirements.	Katie Prichard-Thomas, Chief Nursing Officer	h) Legal obligations on the Trust are brought to the attention of Directors.	
5	<p><b>The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:</b></p> <p>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;</p> <p>(b) That the Board's planning and decision-making processes take timely and appropriate account of</p>	<p>Caroline Lynch, Trust Secretary</p> <p>Katie Prichard-Thomas, Chief</p>	<p>a) The Nominations and Remuneration Committee has responsibility for overseeing the competence and capability of the management team. The Trust has an appraisal system for all individuals.</p> <p>b) The Board of Directors' leadership of the Operational and Strategic Planning processes includes a focus on quality</p>

	<b>Statement</b>	<b>Lead</b>	<b>Commentary</b>
<i>Cont'd</i>	quality of care considerations;	Nursing Officer / Janet Lippett, Chief Medical Officer	strategy and plans. The Board Quality Committee regularly monitors delivery of the Quality Strategy and Quality priorities.
	(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	Katie Prichard-Thomas, Chief Nursing Officer	c) Quality information is produced by Informatics prior to analysis by the Care Groups, Committees and by the Executive. This is triangulated through a collective meeting with all three care groups and the Executive to discuss quality, finance and workforce performance.
	(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	Katie Prichard-Thomas, Chief Nursing Officer	d) A monthly Integrated Board Performance Report including quality, access, operational performance and staffing information and a Finance report is produced for Board which outlines performance at Board level and includes KPIs and scorecard. Metrics are at granular level by theme and by month with a commentary. Prior to the Board, performance is monitored through a monthly performance meeting with the Executive Team and Care Groups to discuss finance, quality performance and workforce to discuss quality performance. Ward to Board has been developed and the Trust has a ward accreditation scheme. Exception reports are published for consideration of the Board.
	(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	Katie Prichard-Thomas, Chief Nursing Officer	e) The Trust drives engagement with key stakeholders through the patient experience committees. Appropriate channels are in place including: Patient Leadership Programme, Patient Standing Conferences, Patient Groups, local and national surveys, Friends & Family Test, PALS, patient stories reported to Board and to our Commissioners. Regular meetings are in place with local Healthwatch and maternity & neonatal voices partnership leads. A stakeholder engagement plan ensures all interested parties are actively involved in the identification and selection of the Trust's quality priorities.

Statement		Lead	Commentary
	(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Katie Prichard-Thomas, Chief Nursing Officer	f) At Board level, the Chief Medical Officer and Chief Nursing Officer have joint responsibility for quality issues to the Board, including assurance on quality governance. The monthly Integrated Performance Report identifies and escalates key quality performance issues to the Board. Within the organisation, an incident reporting system is in place, with a structure for the escalation of incidents to speciality Care Group Clinical Governance meetings, the Quality Governance Committee and to the Executive and Board Quality Committee.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Paul Da Gama Chief People Officer	The Trust Board is compliant with the NHS England Code of Governance in respect of appropriate numbers of Non Executives/Executives.  The Trust is working to improve workforce planning capability to ensure it has optimal staffing moving forward. Regular skill mix reviews take place and adjustments made where required. The Trust also ensures that robust pre-employment checks on all new staff are carried out.

## 2 – Training of Governors

Statement		Lead	Commentary
1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Caroline Lynch, Trust Secretary	A comprehensive induction session is provided for all new governors and for existing governors to refresh their knowledge. In 2025/26, Governors undertook training and development in the following areas: Consultation and engagement session on the Trust Strategy Refresh, Land Purchase and a guided tour of the Rapid Response Lab and a presentation on Brainomix, Artificial Intelligence in Stroke Care and Virtual Hospital. The Chair & Trust Secretary engage regularly with governors.

<b>Title:</b>	<b>Board Assurance Framework</b>
<b>Agenda item no:</b>	11
<b>Meeting:</b>	Board of Directors
<b>Date:</b>	27 May 2026
<b>Presented by:</b>	Caroline Lynch, Trust Secretary
<b>Prepared by:</b>	Caroline Lynch, Trust Secretary

<b>Purpose of the Report</b>	To provide the Board with a summary of the Trust's Key risks reviewed by Board sub-Committees and relevant Executive leads.
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<b>Report History</b>	Finance & Investment Committee: 18 February 2026 Quality Committee: 22 April 2026 People Committee: 7 May 2026 Finance & Investment Committee: 20 May 2026
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<b>What action is required?</b>	
Assurance	
Information	The Board is asked to note the updates on the Framework in relation to the assurances, gaps and actions in place to manage strategic risks.
Discussion/input	
Decision/approval	

<b>Resource Impact:</b>	Not applicable
<b>Relationship to Risk in BAF:</b>	Not applicable
<b>Corporate Risk Register (CRR) Reference /score</b>	Not applicable
<b>Title of CRR</b>	Not applicable

<b>Strategic objectives This report impacts on (tick all that apply)::</b>				
Provide the highest quality care for all				✓
Invest in our people and live out our values				✓
Deliver in partnership				✓
Cultivate innovation and improvement				✓
Achieve long-term sustainability				✓
<b>Well Led Framework applicability:</b>			Not applicable	
1. Leadership <input type="checkbox"/>	2. Vision & Strategy <input type="checkbox"/>	3. Culture <input type="checkbox"/>	4. Governance <input type="checkbox"/>	
5. Risks, Issues & Performance <input type="checkbox"/>	6. Information Management <input type="checkbox"/>	7. Engagement <input type="checkbox"/>	8. Learning & Innovation <input type="checkbox"/>	
<ul style="list-style-type: none"> <li>Board understands the internal and external factors affecting delivery of the plan.</li> <li>Main risks are identified. No significant control issues/ gaps and clear responsibilities.</li> <li>Effective process in place to monitor, understand and address current &amp; future risks</li> </ul>				
<b>Publication</b>				
Published on website		Confidentiality (Fol)	Private	Public <input checked="" type="checkbox"/>

## **1 Purpose**

- 1.1 The Board of Directors has the overall responsibility for ensuring that systems and controls are in place that are sufficiently robust to mitigate risks which may threaten the achievement of the Trust's Strategic Objectives.
- 1.2 The Board achieves this primarily through the work of its sub committees, the use of Internal Audit and other independent inspection and by the systematic collection and scrutiny of performance data to evidence the achievement of the Trust's objectives.
- 1.3 The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method for oversight and management of the Principal Risks to the Trust's objectives.

## **2. Current Position**

- 2.1 The Board Assurance Framework has previously been reviewed by the Quality, Finance & Investment and People committees over the last quarter.
- 2.2 Reviews have also been undertaken with the Chief Operating Officer, Chief Medical Officer, interim Chief Finance Officer, Chief Finance Officer, Chief People Officer and Chief Strategy Officer.

### **Changes to the Summary**

- The BAF risk statements for 5.1, 5.2 and 5.3 and risk description have been updated
- An additional risk has been added - 5.6. If we do not take action on the environmental sustainability agenda, we risk impact on the Trust's reputation

### **Strategic Objective 1**

- CQC IR[ME]R improvement plan has been removed from the Improvement/Action section

### **Strategic Objective 2**

The Control Assurance section has been updated as follows:

- International recruitment programme and birthrate plus, staff psychology support services and sexual safety charter signatory removed
- Talent Management Framework/succession planning, Staff Health & Wellbeing (HWB) Strategy 2025- 28, Occupational HWB services and Management training on staff HWB / people management, Up the Anti Programme, Sexual Safety Charter added

The Gap in Assurance section has been updated as follows:

- Talent Management Framework/succession planning fully embedded, appraisal compliance plan, and Development of management competencies throughout the whole organization removed
- Clear Employee Value Propositions, apprenticeship levy, Capacity of staff physiotherapy service to deliver proactive training to reduce MSK issues, resourcing the Staff Psychological Support Service to develop the service including potential 1-1 support, pace across EDI agenda, Workforce impacts of 3 shifts and delivery of Scaling People Services agenda added

The Improvement/Action section has been updated as follows:

- Audit appraisal effectiveness evaluation, creation of lifetime employee value propositions, senior leadership programme and Align RISE and Leadership with National

management and Leadership framework, NHS Health & Wellbeing Framework Assessment Tool ongoing monitoring, recruit to vacant OH posts, staff preventative health pathway to commence February 2026, review OH triage process for referrals, target OH/ER training to managers in areas with high absence, CPO Driver Metric Focus on Global Majority Representation at Band 8A +Programmes to tackle poor behaviours and drive civility and Update Behaviours Framework, Up the Anti (Anti-Discrimination Trust Wide Programme added

### **Strategic Objective 3**

- Reading and Thames Valley Innovation Partnership, CMO membership of BSPS Board and Implementation of Strategic Partnership reviews recommendations has been added to key controls section
- Executive representation at the APC and ICS meetings. CEO attendance at ICS CEO meetings and STRB and Trust Chair is chair of APC and the Trust hosts the APC also added to key controls section
- Quarterly Strategic Partnership Board has been added to the control assurance section.
- Frequency of the regional assurance interventions and ability of those meetings and engagement with the ICB to influence the activities of other parts of the system and proposals from the ICB on the development of the system including how the system might approach the IHO agenda added to the gap in assurance section
- Engagement with ICB system development programme, CEO and CSO bilateral engagement with partners in Berkshire and Board to Board proposal with BHFT added to improvement/action section

### **Strategic Objective 4**

- Launch of online Improving Together training, Bi-annual review of benchmarking data on productivity and efficiency and Quarterly NOF updates, Scoping of the four strategic programmes and Reading and Thames Valley Innovation Partnership Implementation of Strategic Partnership reviews recommendations added to the control assurance section
- Detailed delivery plans for the strategic programmes including benefits identification, Alignment of strategic programmes and key enablers (esp digital and capital) and Board and executive governance of the strategic programmes added to the gap in assurance section
- Proteus engagement with key programmes, Development of programme delivery plans and benefits and revised governance on innovation and transformation added to the improvement/action section.

### **Strategic Objective 5**

- Existing Green Plan, Land Search review and Political support for land purchase add to the control assurance section.
- Secure options agreements on preferred sites and Complete due diligence on preferred sites added to the improvement/action section.

## **3. Next Steps**

- 3.1 The Board is asked to note the updates to the Board Assurance Framework.

## **4. Attachments**

- 4.1 The following are attached to this report:

Appendix 1 – Board Assurance Framework May 2026

# Trust Board Assurance Framework

## May 2026

### Summary Board Assurance Framework 2026

Strategic Objective	BAF Risk		Risk Appetite Description	Sub Committee	Lead Director
Strategic Objective 1: Delivering the highest quality care for all	1.1	If we allow material lapses in the quality of care, including access to care, the Trust will not meet its regulatory standards for quality and safety	The quality of our services, measured by patient outcomes, safety and experience as well as our ability to be responsive to our patient's is paramount. The Trust has a low appetite to risk that could result in poor quality of care and will seek to avoid taking risks that compromise patient safety. This cautious appetite extends to compliance with Care Quality Commission standards.	Quality Committee	Chief Nursing Officer
	1.2	If we do not deliver our clinical and quality ambitions at the intended pace we will lose opportunities to improve patient outcomes and experience		Quality Committee	Chief Medical Officer
Strategic Objective 2: Supporting our people to thrive	2.1	If we do not recruit and retain a competent workforce we will fail to deliver on the Trust's strategic objectives	The Trust seeks to be recognised through its values as a great place to work. It will innovate and challenge traditional working practices. As such, it is prepared to take a flexible view on the development of its workforce and conditions of employment. There is a medium appetite for risk where this does not compromise staff and values and be proven to benefit patient and staff safety.	People Committee	Chief People Officer
	2.2	If we fail to uphold our Values (CARE and Diversity & Inclusion) the Trust will not be an employer of choice or considered an exemplar organisation for staff		People Committee	Chief People Officer
Strategic Objective 3: Partnering for impact	3.1	If our partners at Place and System fail to deliver operationally there is a risk that the Trust will not deliver against NHS Constitutional standards	The Board is keen to drive the development of integrated care with its local Berkshire West Place and regional (ICS) partners at pace. In doing so, the Board is willing to take decisions where the potential benefits to patients and providers are seen to outweigh risks. It sees the development of new ideas and	Quality Committee	Chief Operating Officer
	3.2	If Berkshire West Place and Thames Valley ICS plans and programmes do not deliver the envisaged improvements in care and value, the Trust's financial and operational performance will be impacted		Board	Chief Strategy Officer

	3.3	If we do not realise the opportunities presented by our strategic partnership with UoR we will not deliver on our education, training and research ambitions.	partnerships as potentially enhancing quality and financial sustainability and so where collectively shared it has a relatively high appetite for integration risk.	Board	Chief Medical Officer
Strategic Objective 4: Driving improvement and enabling innovation	4.1	If we do not continue to invest in digital infrastructure and development we will not be able to deliver Our Strategy and our Clinical Services Strategy and we will face challenges in running a modern efficient healthcare service	The Trust will actively seek and encourage a culture of innovation, transformation and improvement. It is willing to accept a relatively high level of risk associated with opportunities where positive quality of care, service delivery and financial benefits and rewards can be anticipated.	Quality Committee	Chief Operating Officer
	4.2	If we fail to realise benefits/secure commercial advantage from innovation, transformation, improvement and digital investments we will face income shortfalls and will not to be able to deliver our efficiency targets		Audit & Risk Committee Finance & Investment Committee	Chief Strategy Officer
Strategic Objective 5: Building a sustainable future together	5.1	If the Trust does not maintain robust financial control, accurate income reporting, and delivery against plan, there is a risk to financial sustainability, liquidity, regulatory compliance, and organisational reputation	The Board's key objective is to be financially sustainable, with its primary concern being the optimal use of resources to deliver value for money. The Board will view risk and reward and consider return on investment and other benefits or constraints when pursuing business opportunities. The Trust has a low appetite for risks relating to financial control, reporting accuracy, and regulatory compliance, and a moderate risk appetite for investment decisions that deliver clear benefit to patients or staff, where risks are understood and mitigated. The current level of financial risk is above the Trust's stated risk appetite. Actions are in place to reduce this through strengthened financial control, improved reporting, and delivery of the financial recovery plan.	Finance & Investment Committee	Chief Finance Officer
	5.2	If the Trust does not robustly represent itself in national, regional and Thames Valley Integrated Care System decision-making, there is a risk of failing to secure sufficient income to deliver its strategy and strategic objectives		Finance & Investment Committee	Chief Finance Officer
	5.3	If the Trust does not take effective action to deliver its financial recovery and sustainability agenda, there is a risk of continued financial deterioration and reputational impact		Finance & Investment Committee	Chief Finance Officer

	5.4	If we do not create and maintain a built environment suitable for current and future needs, we risk delivery of Our Trust Strategy		Finance & Investment Committee	Chief Strategy Officer
	5.5	If the Trust is not successful in converting the future promise of a new hospital and bring it to fruition sooner than 2040, we risk the ability to deliver on our mission over the long term		Finance & Investment Committee	Chief Strategy Officer
	5.6	If we do not take action on the environmental sustainability agenda we risk impact on the Trust's reputation		Finance & Investment Committee	Chief Strategy Officer

## Strategic Objective 1: Delivering the highest quality care for all

Identified Strategic Risks that we the Board have agreed as having the potential to impact on our ability to deliver this strategic objective -

- If we allow material lapses in the quality of care, including access to care, the Trust will not meet its regulatory standards for quality and safety
- If we do not deliver our clinical and quality ambitions at the intended pace we will lose opportunities to improve patient outcomes and experience

Key Controls	Control Assurance	Gap in Assurance	Improvement / Action	Responsible Committee
<ul style="list-style-type: none"> <li>• CQC programme</li> </ul>	<ul style="list-style-type: none"> <li>• Well led self-assessment</li> <li>• Peer review process</li> <li>• Core service annual updates</li> <li>• Core service self-assessment</li> <li>• Quarterly CQC engagement meetings</li> <li>• CQC Peer Review</li> <li>• CQC Inspection Reports including IR[ME]R</li> <li>• IPC BAF</li> </ul>		<ul style="list-style-type: none"> <li>• Clinical Accreditation Programme implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Board</li> <li>• Quality Committee</li> </ul>
<ul style="list-style-type: none"> <li>• Quality and Clinical Services Regulation including NHS England</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Account</li> <li>• Clinical audit programme</li> <li>• Patient feedback – NHS choices, Friends &amp; Family and Inpatient &amp; Outpatients Annual surveys</li> <li>• Internal Audit</li> <li>• External Audit</li> <li>• Monitoring progress against Quality Strategy</li> <li>• IPR report and watch metrics</li> <li>• Maternity Incentive Scheme</li> <li>• Maternity Strategy</li> <li>• Childrens &amp; Young People Strategy</li> <li>• Continuous Quality Improvement Programme (Improving Together)</li> </ul>	<ul style="list-style-type: none"> <li>• Health Inequalities Delivery Plan</li> <li>• Worry and concern element of Martha's rule</li> <li>• Risks to delivery of access standards</li> <li>• Mixed sex accommodation monitoring due to operational pressures</li> </ul>	<ul style="list-style-type: none"> <li>• Health Equalities Programme</li> <li>• Pilot programme underway</li> <li>• ED worry and concern pilot programme</li> <li>• 2025/26 Elective Activity Plan supported by insourcing, additional premium rate activity and APC system working                             <ul style="list-style-type: none"> <li>• Patient Flow programme</li> <li>• Cancer, Referral To Treatment and ED performance reviews</li> </ul> </li> <li>• Implementation of Childrens &amp; Young People Strategy</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Committee</li> </ul>
<ul style="list-style-type: none"> <li>• Quality reporting schedule</li> </ul>	<ul style="list-style-type: none"> <li>• Safeguarding Mental Health, Learning Disability &amp; Autism annual report</li> <li>• Infection control annual report</li> <li>• Patient relations quarterly reports</li> <li>• Mortality review process</li> <li>• Freedom to speak up (FTSU) reporting to the Board including annual self-assessment.</li> <li>• Bi monthly Quality Governance Committee exception report</li> <li>• Patient Safety Quarterly report.</li> </ul>	<ul style="list-style-type: none"> <li>• Patient Autism Strategy</li> </ul>	<ul style="list-style-type: none"> <li>• Development of Autism strategy and service</li> <li>• Monitoring of Prevention of Future Deaths reports</li> <li>• Learning from deaths quarterly report</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Committee</li> <li>• Board</li> </ul>

<ul style="list-style-type: none"> <li>• Performance management Process</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly Care Group &amp; Corporate performance meetings</li> <li>• Integrated performance report</li> <li>• QIA process to monitor impact of CIP</li> <li>• Quality Committee oversight and annual detailed review of access standards</li> </ul>	<ul style="list-style-type: none"> <li>• Compliance with national access targets</li> <li>• Quality Impact assessments</li> </ul>	<ul style="list-style-type: none"> <li>• Annual review of data / metric and exception reports</li> <li>• Regular EQIA reporting</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Committee</li> <li>• Finance &amp; Investment Committee</li> </ul>
<ul style="list-style-type: none"> <li>• Risk management &amp; incident reporting process</li> </ul>	<ul style="list-style-type: none"> <li>• Risk register review including thematic risk reviews</li> <li>• Incident reporting and learning</li> <li>• LFPSE reporting</li> <li>• PSIRF thematic review/Learning from inquests</li> <li>• Annual report to the Board</li> <li>• Emergency preparedness, resilience &amp; response Procedures Annual Compliance Statement</li> <li>• Maternity Quality Assurance Report to Board</li> </ul>	<ul style="list-style-type: none"> <li>• NPSS training compliance</li> <li>• Oliver McGowan mandatory training compliance</li> </ul>	<ul style="list-style-type: none"> <li>• Mandatory &amp; Statutory Training review</li> <li>• Continuous focus on NPSS and Oliver McGowan training awareness</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Committee</li> </ul>

## Strategic Objective 2: Supporting our people to thrive

Identified Strategic Risks that we the Board have agreed as having the potential to impact on our ability to deliver this strategic objective -

- If we do not recruit and retain a competent workforce, we will fail to deliver on the Trust's strategic objectives.
- Failure to deliver on our Values (CARE and Diversity & Inclusion) will result in the Trust not being an employer of choice or considered an exemplar organisation for staff

Key Controls	Control Assurance	Gap in Assurance	Improvement / Action	Responsible Committee
RBFT People Strategy  RBFT Education Strategy	<u><b>Your Experience</b></u> <ul style="list-style-type: none"> <li>• Recruitment and Retention framework</li> <li>• Staff Survey Reports and Improvement Plans</li> <li>• Guardian of Safe Working Reports</li> </ul>	<u><b>Your Experience</b></u> <ul style="list-style-type: none"> <li>• Appraisal quality measures</li> <li>• GMC survey and NETS survey (Does committee need to be sighted on these?)</li> <li>• Clear Employee Value Propositions</li> </ul>	<u><b>Your Experience</b></u> <ul style="list-style-type: none"> <li>• Audit Appraisal effectiveness evaluation</li> <li>• Targeted recruitment and retention programmes</li> <li>• ICS Joint Initiatives across the agenda</li> <li>• Possibilities to address affordable housing and increase available accommodation for staff</li> <li>• Creation of life time EVP</li> </ul>	People Committee Responsible for All
What Matters Engagement Programme  Annual Staff Survey and results  People Strategy Action Plan	<u><b>Your Development</b></u> <ul style="list-style-type: none"> <li>• Annual medical revalidation</li> <li>• Education strategy – Delivery Progress Updates</li> <li>• Annual Skill Mix Review</li> <li>• NHSE Education Self-Assessment</li> <li>• Talent Management Framework/succession planning</li> </ul>	<u><b>Your Development</b></u> <ul style="list-style-type: none"> <li>• Apprenticeship levy funding</li> </ul>	<u><b>Your Development</b></u> <ul style="list-style-type: none"> <li>• Mandatory Learning Oversight Group programme</li> <li>• MAST and appraisal detailed reviews</li> <li>• Global Majority Aspiring Leaders programme</li> <li>• Senior Leadership programme</li> <li>• Align RISE and Leadership with National management and Leadership framework</li> </ul>	
Chief People Officer Quarterly Report  Workforce Metrics Quarterly Report	<u><b>Your Health</b></u> <ul style="list-style-type: none"> <li>• Health Safety and Wellbeing Champions embedded across the Trust</li> <li>• Staff Health &amp; Wellbeing Group</li> <li>• Staff Health &amp; Wellbeing strategy 2025-28</li> <li>• Staff Health Checks for 40+ yrs old</li> <li>• Occupational Health &amp; Wellbeing services</li> <li>• Improving Staff Experience in relation to Violence &amp; Action</li> <li>• Management training on staff HWB / people management</li> </ul>	<u><b>Your Health</b></u> <ul style="list-style-type: none"> <li>• Addressing the impact of service demand on OH waiting times</li> <li>• Health &amp; Wellbeing Forward Plan</li> <li>• Resourcing the Staff Psychological Support Service to develop the service including potential 1-1 support</li> <li>• Capacity of staff physiotherapy service to deliver proactive training to reduce MSK issues</li> <li>• Implementation of V&amp;A action plan</li> </ul>	<u><b>Your Health</b></u> <ul style="list-style-type: none"> <li>• NHS Health &amp; Wellbeing Framework Assessment Tool ongoing monitoring</li> <li>• Recruit to vacant OH posts</li> <li>• Staff preventative health pathway to commence Feb 26</li> <li>• Review OH triage process for referrals</li> <li>• Target OH/ER training to managers in areas with high absence</li> </ul>	
Chief People Officer Driver Metrics	<u><b>Your Inclusion</b></u> <ul style="list-style-type: none"> <li>• National Equality Standard Reports – WRES, WDES, Gender Pay Gap (GPG)</li> <li>• Behaviours framework and values-based people processes</li> <li>• Equality Forums</li> <li>• Up The Anti programme</li> <li>• Sexual Safety Charter</li> </ul>	<u><b>Your Inclusion</b></u> Pace of improvements across EDI agenda	<u><b>Your Inclusion</b></u> <ul style="list-style-type: none"> <li>• Up the Anti (Anti-Discrimination Trust Wide Programme)</li> <li>• CPO Driver Metric Focus on Global Majority Representation at Band 8A +Programmes to tackle poor behaviours and drive civility</li> <li>• Update Behaviours Framework Sexual Safety Charter Action Plan</li> <li>• Violence &amp; Aggression Action Plan</li> </ul>	

	<p><b><u>Your Future Workplace</u></b></p> <ul style="list-style-type: none"> <li>• Digital Strategy</li> <li>• Hybrid Working</li> <li>• Number of new roles created and implemented</li> </ul>	<p><b><u>Your Future Workforce</u></b></p> <ul style="list-style-type: none"> <li>• Digital Strategy – People Implications</li> <li>• Workforce Transformation and Reform and embedding new roles</li> <li>• Workforce impacts of 3 shifts</li> <li>• Delivery of Scaling People Services Agenda</li> </ul>	<p><b><u>Your Future Workforce</u></b></p> <ul style="list-style-type: none"> <li>• NHS LTWP Implementation</li> <li>• Workforce transformation embedded into annual planning process</li> <li>• Digital Strategy and Technological Enablement</li> </ul>	
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### Strategic Objective 3: Partnering for Impact

Identified Strategic Risks that we the Board have agreed as having the potential to impact on our ability to deliver this strategic objective -

- If our partners at Place and System fail to deliver operationally there is a risk that the Trust will not deliver against NHS Constitutional standards and the Trust's National Oversight Framework (NOF) position will be at risk.
- If Berkshire West Place and Thames Valley ICS plans and programmes do not deliver the envisaged improvements in care and value the Trust's financial and operational performance will be impacted
- If we do not realise the opportunities presented by our strategic partnership with UoR we will not deliver on our education, training and research ambitions

Key Controls	Control Assurance	Gap in Assurance	Improvement / Action	Responsible Committee
<ul style="list-style-type: none"> <li>• Active involvement of CEO and Director team in BWP, ICS and APC programme governance</li> <li>• Executive representation at the APC and ICS meetings. CEO attendance at ICS CEO meetings and STRB .</li> <li>• Trust Chair is chair of APC and the Trust hosts the APC</li> <li>• Involvement of senior leaders, clinicians and managers in service design and programme delivery at Place, ICB and Network level</li> <li>• Regular bilateral meetings at exec level with BWP and ICS colleagues</li> <li>• ICS and BWP priority work programme and project scopes</li> <li>• Reading and Thames Valley Innovation Partnership</li> <li>• CMO membership of BSPPS Board</li> <li>• Implementation of Strategic Partnership reviews recommendations</li> </ul>	<ul style="list-style-type: none"> <li>• Bi-monthly report to board on progress of ICS and ICP as part of CEO report</li> <li>• ICS and BWP leadership meetings</li> <li>• Regional tripartite assurance meetings between the Trust, ICB, and NHS England.</li> <li>• Programmes for ICS and Place reported on to Unified Exec monthly.</li> <li>• APC Board</li> <li>• Quarterly Strategic Partnership Board</li> </ul>	<ul style="list-style-type: none"> <li>• Frequency of the regional assurance interventions and ability of those meetings and engagement with the ICB to influence the activities of other parts of the system</li> <li>• Proposals from the ICB on the development of the system including how the system might approach the IHO agenda.</li> <li>• NHSE and ICB transition plan</li> </ul>	<ul style="list-style-type: none"> <li>• APC &amp; Berkshire West Place Programme Delivery</li> <li>• Engagement with ICB system development programme</li> <li>• CEO and CSO bilateral engagement with partners in Berkshire</li> <li>• Board to Board proposal with BHFT</li> </ul>	<ul style="list-style-type: none"> <li>• Board of Directors</li> </ul>
		<ul style="list-style-type: none"> <li>• Implementation of Strategic Partnership reviews recommendations</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Committee</li> </ul>	

## Strategic Objective 4: Driving improving and enabling innovation

Identified Strategic Risks that we the Board have agreed as having the potential to impact on our ability to deliver this strategic objective -

- The capability culture and capacity in the organisation to deliver change
- Our continued commitment to invest in and develop our digital environment
- Our ability to realise benefits/secure commercial advantage from innovation, investment and digital investment

Key Controls	Control Assurance	Gap in Assurance	Improvement / Action	Responsible Committee
<ul style="list-style-type: none"> <li>• Improving Together</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated Performance Report</li> <li>• NHS Impact CQI (Improving Together) Maturity Matrix</li> <li>• Launch of online Improving Together training</li> </ul>		<ul style="list-style-type: none"> <li>• Full implementation of Improving Together programme</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Committee</li> </ul>
<ul style="list-style-type: none"> <li>• Trust Transformation Programme</li> <li>• Digital Hospital Committee</li> <li>• Target Operating Model and revised DDaT structure</li> </ul>	<ul style="list-style-type: none"> <li>• Scoping of the four strategic programmes</li> <li>• Turnaround and Transformation reports to F&amp;I</li> <li>• Efficiency and Productivity Committee</li> <li>• System Transformation Board</li> <li>• Confirmation of the Trust Projects for 2025/26 and associated benefits</li> <li>• Bi-annual review of benchmarking data on productivity and efficiency</li> <li>• Quarterly NOF updates</li> </ul>	<ul style="list-style-type: none"> <li>• Detailed delivery plans for the strategic programmes including benefits identification</li> <li>• Confirmation of 2026/27 Trust Projects aligned to the strategic programmes and associated benefits</li> <li>• Alignment of strategic programmes and key enablers (esp digital and capital)</li> <li>• Board and executive governance of the strategic programmes</li> <li>• Progress of APC and system savings</li> </ul>	<ul style="list-style-type: none"> <li>• Proteus engagement with key programmes</li> <li>• Development of programme delivery plans and benefits</li> <li>• Revised governance on innovation and transformation</li> <li>• Reporting on progress to EPC and F&amp;I</li> <li>• Executive engagement with APC and SRTB – focus on actions and delivery</li> </ul>	<ul style="list-style-type: none"> <li>• Finance &amp; Investment Committee</li> </ul>
<ul style="list-style-type: none"> <li>• Commercial Strategy</li> <li>• R&amp;I programme</li> </ul>	<ul style="list-style-type: none"> <li>• Digital Strategy</li> </ul>	<ul style="list-style-type: none"> <li>• Recruitment to new DDaT structure within the current financial envelope</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of the 2025/26 roadmap of projects that digitally enable clinical improvement</li> <li>• Refreshed Digital Strategy due by end of April 2026</li> </ul>	<ul style="list-style-type: none"> <li>• Finance and Investment Committee</li> </ul>

	<ul style="list-style-type: none"> <li>• Monthly finance reports</li> <li>• Commercial strategy updates</li> </ul>	<ul style="list-style-type: none"> <li>• Cycle of reporting on commercial strategy</li> <li>• Commercial capacity within the organisation</li> </ul>	<ul style="list-style-type: none"> <li>• Commercial Strategy (part of the Finance Strategy) to be added to work plan bi-annually</li> </ul>	<ul style="list-style-type: none"> <li>• Finance &amp; Investment Committee</li> </ul>
	<ul style="list-style-type: none"> <li>• Annual update on R&amp;I to Quality Committee/R&amp;I Strategy</li> <li>• Reading and Thames Valley Innovation Partnership Implementation of Strategic Partnership reviews recommendations</li> </ul>			<ul style="list-style-type: none"> <li>• Quality Committee</li> </ul>

## Strategic Objective 5: Building a sustainable future together

Identified Strategic Risks that we the Board have agreed as having the potential to impact on our ability to deliver this strategic objective:

If the organisation spends at a rate greater than the rate of income received, it will continue to be in an overall deficit position and thus not generate sufficient cash to meet its day to day liquidity requirements, Furthermore, if the organisation continues to rely on non-recurrent income, such as deficit support funding, to fund the recurrent cost base then there is a risk to long-term sustainability. There is currently revenue cash support available for planned revenue deficits to ensure providers do not have to reduce capital investment to achieve liquidity. However, should the Trust exceed the planned deficit then there is a risk to capital investment which in turn risks aging equipment replacement and critical infrastructure upgrades not being action.

The Trust's estate is aged creating operational and strategic challenges. It is imperative that we seek to bring the promise of a new hospital to fruition and continue to secure investments into the existing estate to support delivery of services over the next two decades.

Key Controls	Control Assurance	Gap in Assurance	Improvement / Action	Responsible Committee
<b>Finance</b>				
<ul style="list-style-type: none"> <li>• Standardised Annual Planning following NHSE guidance and timetable</li> <li>• Medium-term planning</li> <li>• Internal performance management system:</li> <li>• Monthly financial reporting system</li> <li>• Run rate reporting</li> <li>• Standardised monthly forecasting</li> <li>• Standardised internal expenditure controls (enhancements to the SFIs) including workforce controls</li> <li>• Standing Financial Instructions (SFIs)</li> <li>• Daily/ weekly/ monthly cash management processes</li> </ul>	<ul style="list-style-type: none"> <li>• All annual plans: capital, revenue, efficiency, workforce and activity approved through EMC, Board committees and Board</li> <li>• External Audit annual process</li> <li>• Internal Audit annual work plan</li> <li>• Counter Fraud Annual Plan</li> <li>• Executive and Board "go and Sees" giving the opportunity to triangulate activity, workforce and finance data with service experience</li> <li>• Detailed Monthly and Quarterly submissions to NHS England and TV ICB</li> <li>• Standardised revenue forecasting shared with EMC, F&amp;I and Board identifying mitigating actions where required</li> <li>• Capital forecasting shared with CPC identifying mitigating actions where required</li> <li>• Budget approval process</li> <li>• Monthly reports to EMC, Finance &amp; Investment Committee, minutes to demonstrate appropriate discussions</li> <li>• Monthly performance meetings with Care Groups and corporate areas</li> <li>• HFMA Financial Sustainability checklist</li> <li>• Monthly Efficiency &amp; Productivity Committee</li> <li>• Financial performance as a driver metric for all care groups/ corporate directorates</li> <li>• Cash Committee set up within the Trust governance framework to ensure executive and non-executive oversight of cash preservation decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Standardised benchmarking of expenditure using NHSE performance packs, model hospital and service line reporting (SLR)</li> <li>• Lack of oversight of income delivery by care groups</li> <li>• Lack of alignment between workforce and finance on WTE figures</li> <li>• Lack of recognition of WTE plans for 25/26 by care groups and corporate directorates</li> <li>• Refresh Finance Strategy (aligned to Trust Strategy &amp; NHSE 10 Year Plan)</li> <li>• Application of new NHSE guidance on Strengthening Financial Management to be reviewed to identify any gaps. Review likely to identify a gap in non-pay controls and the requirement for a finance recovery committee</li> </ul>	<ul style="list-style-type: none"> <li>• Using the RBFT LTRM, develop a robust 3-year revenue operating plan and 4-year capital plan that delivers all performance requirements following NHSE guidance, business rules and timetable</li> <li>• Continue to review how to get better traction with run rate improvement, deciding on how best to progress income improvements and costing methodologies within the finite resources of the finance team</li> <li>• Further develop a more robust approach to forecasting which incorporates a review of robustness of the prior period forecast.</li> <li>• Continue to seek to convert efficiencies into recurrent savings in 2025/26 and build a consistent approach to efficiencies expecting no more than 1/3rd to be delivered non-recurrently each year</li> <li>• Complete actions in the finance function improvement plan</li> </ul>	<p>Finance &amp; Investment Committee</p> <p>Finance &amp; Investment Committee</p> <p>Finance &amp; Investment Committee</p> <p>Finance &amp; Investment Committee</p> <p>Audit &amp; Risk Committee</p>

<b><u>Estates &amp; Facilities</u></b>				
<ul style="list-style-type: none"> <li>• Management of backlog maintenance including Critical Infrastructure Risks</li> <li>• Food safety/catering standards</li> <li>• Estates Programme Committee</li> <li>• Estates Maintenance supply and management arrangements</li> <li>• Estates Governance &amp; Compliance Oversight Group</li> </ul>	<ul style="list-style-type: none"> <li>• NHS Premises Assurance Model (PAM)</li> <li>• External Regulator Inspections (e.g. Fire)</li> <li>• MODEL hospital</li> <li>• ERIC (Estates Reference Information Collection)</li> <li>• Six Facet Survey</li> <li>• PLACE assessment</li> <li>• Estates management and governance process including Hospital Technical Management (HTM) compliance</li> <li>• Capital prioritisation process</li> <li>• Audit processes</li> <li>• Estates &amp; Facilities Improving Together metrics</li> <li>• Estates &amp; Facilities Health &amp; Safety dashboard report</li> <li>• Geo-technical site survey with specific recommendations and actions</li> </ul>	<ul style="list-style-type: none"> <li>• Capacity, resourcing and expertise constraints in the directorate (National shortage and market salaries of project management and engineers with estate skills)</li> <li>• HTM compliance due to backlog maintenance</li> <li>• High and medium Critical Infrastructure Risks</li> <li>• Exponential increase in running costs (utilities and maintenance) as a result of the New Hospital Programme review announcement and increasing backlog maintenance.</li> <li>• Sources of capital for major estate programme and to address backlog maintenance</li> <li>• Up to date Estates Strategy and Masterplan</li> <li>• Effective utilisation of estate</li> </ul>	<ul style="list-style-type: none"> <li>• Prioritisation and risk management of backlog maintenance and Critical Infrastructure Risks</li> <li>• Review of risk register ratings and mitigations in light of the New Hospital Programme review announcement.</li> <li>• Investment plans and funding related to Estates Strategy/Masterplan.</li> <li>• Development of Masterplan, development control plan and asset management plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Finance &amp; Investment Committee</li> <li>• Audit &amp; Risk Committee</li> <li>• Finance &amp; Investment Committee</li> </ul>
<ul style="list-style-type: none"> <li>• Net Zero Carbon Plan</li> </ul>	Existing green plan	<ul style="list-style-type: none"> <li>• Funding and delivery of Net Zero action plan</li> <li>• Tracking and measurement of in year carbon reduction</li> <li>• Lack of dedicated resource</li> </ul>	<ul style="list-style-type: none"> <li>• Revenue/budget setting to consider and reflect allocation and resources</li> <li>• Mapping capex with carbon impact</li> <li>• Establish resources/commitment/capital/revenue to deliver published Green Plan intentions</li> </ul>	<ul style="list-style-type: none"> <li>• Finance &amp; Investment Committee</li> </ul>
<ul style="list-style-type: none"> <li>• New Hospital</li> </ul>	<ul style="list-style-type: none"> <li>• Government confirmation of funding of £2bn for a new hospital in 2040</li> <li>• Land search review completed</li> <li>• Proposals with NHP to progress land purchase</li> <li>• Stakeholder support to explore how to bring forward the new hospital</li> <li>• Political support for land purchase</li> </ul>	<ul style="list-style-type: none"> <li>• Promise of new hospital is subject to multiple general elections</li> <li>• Focus of NHP is on wave 1 and 2 Trusts</li> <li>• Decision making at NHP is subject to political influence</li> <li>• Trust has no access to funding until 2030</li> <li>• Both of the preferred sites for the new hospital are likely to be marketed during 2026/27</li> </ul>	<ul style="list-style-type: none"> <li>• Secure options agreements on preferred sites</li> <li>• Complete due diligence on preferred sites</li> <li>• Develop business case for purchase of preferred site</li> <li>• Explore creation of a taskforce with local partners to influence national government on the case for hospital investment</li> <li>• Continue to engage with NHP through the wave 3 engagement process</li> </ul>	<ul style="list-style-type: none"> <li>• Finance &amp; Investment Committee</li> </ul>
<b><u>Health &amp; Safety</u></b>				
<ul style="list-style-type: none"> <li>• Health &amp; Safety Policy</li> <li>• Health &amp; safety mandatory training</li> <li>• Risk Assessments / Corporate Risk Register</li> <li>• Health &amp; Safety governance processes</li> </ul>	<ul style="list-style-type: none"> <li>• Health &amp; safety Committee reporting to IRMC/EMC/Audit &amp; Risk Committee/ Board</li> <li>• Health &amp; Safety dashboard</li> <li>• RIDDOR reporting</li> <li>• Contractor reporting on Specialist compliance on critical estates safety</li> <li>• Health &amp; Safety Moment at Public Board</li> <li>• Big 4 Health &amp; Safety messages</li> <li>• Health &amp; Safety Training</li> </ul>	<ul style="list-style-type: none"> <li>• Contractor assurance required validation</li> <li>• Security Manager to be recruited</li> <li>• Substantive Health &amp; Safety Advisor not in post</li> <li>• Face to Face manual handling</li> </ul>	<ul style="list-style-type: none"> <li>• Streamline automatic data collection and dashboard in IPR with thematic analysis</li> <li>• Reshaping delivery of hard FM Services</li> <li>• Advisory assurance by Internal Audit (to move to S02)</li> </ul>	<ul style="list-style-type: none"> <li>• Audit &amp; Risk Committee</li> </ul>

<b>Title:</b>	<b>Corporate Risk Register</b>
<b>Agenda item no:</b>	12
<b>Meeting:</b>	Board of Directors
<b>Date:</b>	27 May 2026
<b>Presented by:</b>	Katie Prichard-Thomas, Chief Nursing Officer
<b>Prepared by:</b>	Dawn Estabrook, Head of Risk

<b>Purpose of the Report</b>	To update the Board on the Trust's Management of risk including the review of the Corporate Risk Register
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<b>Report History</b>	Finance & Investment Committee 20 <sup>th</sup> May 2026 Audit & Risk Committee 13 <sup>th</sup> May 2026 People Committee 7 <sup>th</sup> May 2026 Integrated Risk Management Committee 1 <sup>st</sup> May 2026
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<b>What action is required?</b>	
Assurance	✓
Information	✓
Discussion/input	✓
Decision/approval	✓

<b>Resource Impact:</b>	
<b>Relationship to Risk in BAF:</b>	
<b>Corporate Risk Register (CRR) Reference /score</b>	
<b>Title of CRR</b>	

<b>Strategic objectives</b> This report impacts on (tick all that apply)::				
Delivering the highest quality care for all				✓
Supporting our people to thrive				✓
Partnering for impact				✓
Driving improvement and enabling innovation				✓
Building a sustainable future together				✓
<b>Well Led Framework applicability:</b>				Not applicable <input type="checkbox"/>
1. Leadership ✓	2. Vision & Strategy ✓	3. Culture ✓	4. Governance ✓	
5. Risks, Issues & Performance ✓	6. Information Management <input type="checkbox"/>	7. Engagement <input type="checkbox"/>	8. Learning & Innovation <input type="checkbox"/>	

<b>Publication</b>				
Published on website		Confidentiality (FoI)	Private	Public

## 1 Executive Summary

This discussion paper provides the Board with an update on the Trust's corporate risks and recommendations from the Integrated Risk Management Committee (IRMC) on Friday 1<sup>st</sup> May 2026

## 2 Corporate Risk Register

The table below outlines the current corporate risks

Datix ID	Title	Current Risk Rating	Previous Risk Rating	Target Risk Rating	Outcome of IRMC
5080	Fire Safety	20	20	4	Approved
7442	Maternity Block Fire Safety Risk	20	N/A	6	Approved
4183	Management of Estates Infrastructure / Backlogged Maintenance	20	20	6	Approved
4170	Risk of Cyber-Attack	16	16	1	Approved
6320	New Hospital	16	16	4	Approved
4172	ED Capacity & compliance	16	16	8	Approved
4839	North Block East Wing	15	15	6	Approved
6302	Failure of Trust central digital connectivity centre	15	15	4	Approved
5995	Failure to achieve elective standards targets	12	12	6	Approved
4241	Compliance with cancer standards due to capacity issues in diagnostic modalities	12	12	8	Approved
4182	Risk to achieving in-year financial targets	12	12	4	Approved

5698	Risk to compliance of DM01 Standard	12	12	4	Approved
5601	Potential geological/sink hole risk across RBH Estate	12	12	6	Corporate risk to be closed and risk moved to Estates & Facilities risk register
6571	Risk of failure of Trust communication platform	12	12	4	Approved
6319	Age and condition of Trust lifts	12	12	9	Approved
699	PTL Dashboard - Lack of Access & Information	12	12	4	Approved
5697	Violence and aggression against staff	12	12	4	Approved
4460	Outbreaks of infectious conditions	12	12	9	Risk likelihood to be reduced and closure of corporate risk
5717	Risk following significant power failure incident	9	9	4	Approved

It was noted that the high level risks for Estates & Facilities remained largely unchanged, particularly those related to fire safety that required sustained capital investment, including within maternity services.

Two new potential corporate risks are to be scoped:

- Complaints including response time and reputational risk
- Martyns Law potential financial, operational and compliance risk

The Committee reviewed the risk escalation process and risk matrix as part of the annual review cycle. It was confirmed that the process and approach continued to be aligned with current guidance and other organisations. It was agreed that no changes were required at this time.

### 3. Conclusion

The Board is asked to consider whether the BAF or CRR reflects those operational or strategic risks that will impact on the Trust's ability to operate as desired and achieve its strategic objectives.

**Board Work Plan 2026**

Focus	Item	Lead	Freq	Nov-25	Jan-26	Mar-26	May-26	Jul-26	Sep-26	Nov-26
Delivering the highest quality of care for all	Winter Plan	DH	Annually							
Supporting our people to thrive	Patient Story	Exec	Every							
	Staff Story	Exec	Every							
0	Quarterly Forecast	FK	Quarterly							
	2026/27 Capital Plan	FK	Annually							
	Operating Plan/ Business Plan 2026/27	AS	Annually							
	The Green Plan	FK	Annually							
Driving improvement and enabling innovation	Standing Financial Instructions	FK	Annually							
	Trust Strategy Refresh	AS	Nov-25							
Other / Governance	Chief Executive Report	SM	Every							
	Board Assurance Framework	CL	Bi-Annually							
	Corporate Risk Register	KP-T	Bi-Annually							
	Integrated Performance Report (IPR)	Exec	Every							
	NHSE Annual Self-Certification	FK/CL	Annually							
	Standing Orders Review	CL	Annually							
	Board Work Plan	CL	Every							